Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:25 2009 Edward W. Ash Tune 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3527 Old Frederick Road Baltimore Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M M 2 □ F Yrs 10/5/23 Virginía Director 216-18-0468 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Mcdical Examinat must be notified at 1 Nes 2 No Director MD n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 USA 2669 Wilkens Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 DXes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B & 0 Railroad 12 Master Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha S. Klein Richard H. Ash ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2669 Wilkens Ave. Baltimore, Maryland 21223 Howard / Daughter Christine 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery : 6/26/09\_ Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Li 3620 Wilkens Ave. Baltimore, Maryland mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, his one cause or such line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or eart failure. List Immediate Cause (Final years **Physician** Tale disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performe 1 ☐ Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

within 24 hours To the Funeral

State Registrar 29b. Signature and life of certifie

31. Date filed (Month, Day, JUN 2 6 2

Year)

DHMH 17 Rev 1/2001

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

29d. Date signed (Month, Day, Year)

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 200 9 **Physician** MARY 7:15A M AYERS JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BRIGHTWOOD GENESIS NURSING CENTER LUTHERVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 5-8-1921 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F MARYLAND 88 Director 214-12-1908 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified at 1 □XYes 2 □ No Director N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 may injury or other traumatic event, the Medical Examiner must be n once. USA 14. Race - American Indian by Funeral 21215 2501 VIOLET AVE. APT 705 N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify Specify: 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC -0-HOUSEKEEPING -12-17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be မ IDA MAE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 POPLAR GROVE ST. BALTIMORE, MARYLAND 21216 JAMES MORKIS (NEPHEW) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ZION CEMETERY 6-22-2009 BALTIMORE, MARYLAND 21. Signatur D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. BALTIMORE, MARYLAND 21217 1721-27 N. MONROE ST. 23a. Pary Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shot, or heart failure. List only one cause on each line.

Immedi — Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine nyperkunion lospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred ₩ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) santas la Reite Registrar

and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year 1. Decedent's Name (First, Middle, Last) Month Dav Physician Bride alexia 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Iniversity of Maryland Medical Center Social Security Number 10. Sex **Examiner** Baltimore 8 Date of Birth (Month, Day, Year) Sept. 29, 1934 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours 479-36-2366 Iowa Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dipartment of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, If "Medical Examination is to indiffed at 1⊈Yes 2□No Director Woodbury Moville Iowa 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 51039 U.S 833 Meadow Drive . A Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2√2 No Specify. Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander McGowan Helen Tolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>James M. Bride</u> 833 Meadow Drive, Moville, Iowa 51039 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Michael s
Catholic Cemeter 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-29-09 Kingsley, Iowa 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A mukael 6009 Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 years melanoma Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Ves 2 No certificate has page 2 □ No 1 ☐ Yes 1 ☐Yes Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Injury (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

10

31. Date filed (Month, Day, Year) State Registrar

SO MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denve & face

22 S. greene St

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death . Decedent's Name (First, Middle, Last) Month Physician 2009 une /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year)
Dec. 2,1957 Washington, DC If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🏋 F 577-76-7554 51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 X Yes 2 □ No Director DC Washington, DC 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20001 USA 32 Bryant Street, NW Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes. Give Specify: ρ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Administrative Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) or other traumatic event, Be Unknown Helen C. Gaither ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 6330 Hardwood Drive 19a. Informant's Name/Relationship (Type. Print) of Health Barbara A. Richardson/Sister Lanham, MD20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 6/20/09 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses 3821 14th Street, NW, Washington, DC 20011 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Tart 1. Enter the disse, or complications that caused to shock, or heart follore. List only one cause on each line. Immediate Cause Final Jepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Vear Month in the past 12 months?
1 ☐ Yes 2 📈 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 🗌 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🗶 No Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မှ 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death Date of Injury 28b. Time of Certification: (Month, Day Year) Injury 1.X Natural 5 Pending investigation 1 🗌 Yes 2 □ No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only

Box 68760, P.O. Division of Vital Records, 24 hours a To the I within 2

Baltimore, Maryland 21215-0036

State

Registrar DHMH 17 Rev 1/2001

CAMPBELL DOK

29b. Signature and title of ceptifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

JUNE 12 2009

**ORIGINAL** 

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margaret Ewen Blazer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 8. Date of Birth (Month, Day, April 29 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) . 1926 **Funeral** Hours 1 M 2 X F Scotland 206-14-5092 83 Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. Counfy 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 21228 USA 300 Stonewall Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White If Yes, Give Year or Dates: 1 □Yes 2 No Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Meikle Fotheringham Margaret Anderson Findlay ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
300 Stonewall Road; Catonsville, Maryland 21228 19a. Informant's Name/Relationship (Type. Print) Son Tom Blazer 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee MOIDSO 23a. Part 1. Enter th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HYPERTENSION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) 1∐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28b. Time of Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner P.O. Box 68760 Division of Vital Records, within 24 hours after death

To the Funeral Director:
completely filled in by the f To the Hospital

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

show

Department of Health and Mental Hygiene. Important: If item 23a or 28a-f shov any Injury or other traumatic event, the Medical Examination is ust by motified any Injury or other traumatic event, the Medical Examination is ust by motified.

signed by the attending physician and be detached for use as the burial-tran Medical

29a. Certifier

29b. Signature and

After this certificate has been

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Diffective Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D005368

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 09 Month. **Physician** OLM 0 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4ver140 Chalarove If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2**X**F MD Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified 21 once. Baltimore MD 1XYes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number halarove 1100 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify. Specify: Black Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AON COnsultants dministrative/tssistant 12tharade Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Burd Elizabeth William ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chalgrove Avenue Baltimore MD 21215 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, MD 06/27/09 Memoria Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaushn C. Greene Funeral SVO 21. Signature of Funeral Service Licensee Road Randallstown MD21133 V Clu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** one month PATIC disease or condition resulting in death) /Medical Due to (gras a consequence of): Examiner metas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been accounted to the Funeral Director: breast P.O. Box 68760, Cancinging Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ፩ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated

0 State 29b. Signature and title of certifier

MANSHALL

bull ll

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

6569

32. Registrar's Signature

29c. License number

Charles Street

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland		artment of He rtificate of D			giene Reg. No.	2009	20507		
		Decedent's Name (First, Middle, La	st)				2. Date of De	ath	Year	3. Time of Death		
Physici /Medi		ROSE M. C	AMPAGNA				JUNE.	25 25	2009	155 PM		
Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or L		10	4c, County of Death MO BALTIMORE				
			ALLSTOWN		RANDALL				~~ (			
Funeral		5. Social Security Number 6. 5	□M 257F	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	v Year)	9. Birt	hplece (State or Foreign		
Director		212-30-1852 Usual Residence of Decedent	90	113.			Aug. 2	7, 19	18	Maryland		
land ow		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits		
Many a-f sh	tor	MD Balt	imore		Lochear	n				1 ☐ Yes 2 🛣 No		
th the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?		
23a c	rai	6813 West Ric	lge Road		21207				U.S.A.			
tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 1	<ol> <li>Race - Ame Black, Whit</li> </ol>			
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		;	Specify:	White		
be filed within 72 hours after death with the Marylan ital Hygiene. Indoubler than "natural", or Items 23a or 28a-f show event, the Medical Evatrative interities by citified at		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupati	ion		16b. Kin	nd of Business			
Methon 72	piet	(Specify only highest gr.	ade completed) College (1-4or 5+)	(Give life.	kind of work done du DO NOT use retired)	ring most of work	ing					
d with	Completed	8			Waitres				Restau	ırant		
d oth	Be (	17. Father's Name (First, Middle, Last			1	8. Mother's Name	•		Sumame)			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28s-f show aumatic event, Ite Maritial Event the interest interest in the Incillish at	2		P. D'Antoni			Anna	-		Town Chats	Ti- Codo)		
12 sh h and 7 is rr traum		19a. Informant's Name/Relationship			ng Address (Street an				22.2	Zip Code)		
1 and Health em 27		Jerome D'Antoni 20a Method of Disposition	Brother 20b. P		Cobb Road position (Name of matory or other place)		ille, M Date		1208 cation - City or	Town, State		
Pages nent of 1 int: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	THemoval nom State		matory or other place, e National		30,2009	Do 1	timoro	, Maryland		
그 문문을 .		21. Signature of Euneral Service Lice			2. Name and Address		1824 Re					
permit. Dep rit Import any Inj		Stephen	m Jens	W E	Line Funer				wn, MD	21136		
-7174		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the death	n. Do not en	ter the mode of dying,	such as cardiac	or respiratory a	arrest,		Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition	SEPSIS							Onset and Death		
/Medical	Н	resulting in death)	Due to (or as a consequ							11 2015		
Examiner	_	Sequentially list conditions, if any, leading to immediate	b. TNEUMOI							4 DHYS		
ed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or as a consequ	uence or):								
xecul and	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):								
icate be executed physician and s the burial-transit	dicai	(	d									
death certifics a attending ph	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		☐Ectopic pregnancy			2	23d. Date of de Month	livery Day Year		
e deal	sicie	in the past 12 months?	4☐Pregnant at time of do		Other (specify)				MONTH	Day Teal		
es that the death cer igned by the attendin be detached for use		9 Li Unknown								o the cause of death?		
signe d be c	l by	CHRONIC OBSTY	RUCTIVE PULMO	MAR)	1 DISEA	SE	1 🗆	Yes 2	_No 3 _ P	robably 4 Dunknown		
w requir been si should	Completed	<u></u>	NOCT VS				24a. Wa.	s an	24b. Were a	utopsy findings available		
he lav	dmo						auto perf	ormed?	prior to death?	completion of cause of s 2 \( \subseteq \text{No} \)		
sician: The law scertificate has b lirector, page 2 s	e C	25. Was case referred to medical				26. Place of Deal		2 No	1 19	\$ 2010		
ysicia ysicia is ceri	O B	examiner? 1 Tes 2 To	Hospital: 1 Inpatient 2	ER/Outpatie	Other				6 □Other (Sp	ecify)		
ding Phys	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at ?	28d. Describe	how injur	y occurred			
eath. or: Al	catic	2 Accident investigation			M 1 □ Y	es 2 No						
or Att	Certification:	3 Suicide 6 Could not determined		ome, farm, st y)	reet, factory, office			(Street and own, State)		Rural Route Number,		
pital ours a eral [		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge deal	th occurred at the time	e date and place	and due to the	e cause(s)	and manner a	us stated.		
To the Hospital or Attending Physician: The law requires that the death certifully within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my opi	inion, death occur	red at the time	, date and	place, and du	e to the cause(s)		
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	-, ^		29c. License				e signed (Mor	-		
		> Dem Whit	efred CRN	P	R08					, 2009		
10		30. Name and address of person who	completed cause of death (Item	1 BER	TURDAD.	RANDA	LL STOL	m,	MD 2	u133		
St Regist	ate rar	31. Date liled (Month, Day, Year)  JUN 2 6 2009	1	par	w							

29b. Signature and title of certifier

29a. Certifier (Check only one)

**Physician** /Medical

**Examiner** 

To Be Completed by Funeral Director

**Funeral** 

Director

	Pleas	se Type or							-		egible.		
For		State o	of Maryla		•			and M	ental Hyg	jiene			
1 - State Registrar					Certit	ficate of	Death		A	eg. No.	200	9 :	20508
1. Decedent's Name	(First, Middle	, Last)							2. Date of Dea	th Day	Yea		ne of Death
L 1305	e 1	Helpin	Ce	PO	ZS			-	June	25	_	5 00	.Zef M
4a. Facility Name (II	not institution	, give street and nu	mber)	•	41	o. City, Town,	or Location of	of Death		4c. C	ounty of De		
Glen	But	nie Hea	allh C	and	1 Kel	nab-	Glen	n Bu	inie	IA	nne	Ari	indel
5. Social Security No		6. Sex XX 1 □ M 2 □ F	7. Age (In yr		M	Under 1 Year onths Days		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. E	Birthplace (S Country)	tate or Foreign
212.36.4587		10 M 20 F	84	4 Y	rs.				OCT 10,	1924		ÝA	
Usual Residence of 10a. State	Decedent 10b. County		100.0	City, Town	or Locatio	nn.						10d Insi	de City Limits
	,	SIND EI				01,							Yes 2∏No
MD	ANNE A	RUNDEL	GLI	EN BUR		101 71-0-1-				0 014-			XX
10e. Street and Nun						10f. Zip Code				og. Citiz	en of What	Country?	-
1703 CARD	INAL EST				1	21061		1 0 /-		1.	USA		
11. Marital Status		Armed Fo	edent Ever in	U.S.	13. Was	Decedent of s, specify Cul	Hispanic Ori ban, Mexican	gin? (Spec i, Puerto P	cify Yes or No- Rican, etc.)	1.	4. Race - Ar Black, Wh	merican India nite, etc.	an,
1 ☐ Never Marrie		If Yes, Gi Year or D	ve		1 🗆	Yes ŽÄNo	Specify:			1	Specify:	HITE	
(Speci	15. Decedent ify only highes	s Education t grade completed)		11 (	(Give kind	's Usual Occu of work done	during most	t of workin	g i	16b. Kin	d of Busines	ss/Industry	
Elementary/Secon	ndary (0-12)	College (	1-4or 5+)			NOT use retire	9d)			011			
47. 5-11-11-11-11	Final Middle 1	4\			HUMI	EMAKER	T 40 11 11		(F) - 1 14: 14: 1		N HOME		
17. Father's Name (		.ast)							(First, Middle, I	viaiden S	urname)		
JAMES F.									. BASS				
19a. Informant's Na		ip (Type. Print)		19b.	Mailing A				Route Number	-			
RONALD D.			SON		1703		L ESTATI		GLEN BURI				
20a. Method of Disp 1XXBurial 2 ☐ 4 ☐ Donation	Cremation	3 XXRemoval from	State	Place of I cemetery	v, gremato	n <i>(Name of</i> ery or other pla ETERY		Da JUNE 3	o, 2009		SPORT,	or Town, Sta TN	te
	peral Service L	icense	M0114	18		ame and Addr FUNERA			IRNIE, MD	2106	1		D.
		con plications that of			-				- 6-			Approx	kimate
23a. Part 1. Enter th shock, or hear Immediate Course (I	thoilure Lis∖o Final	only one cause on e	each line.	1			3,		1	,		Interva	al Between and Death
disease or condition resulting in deal	1	_ a	1151	eri	ING	12.1	Dem	en	ua			12	Jears
		Due to	(or as a conse	equence of	f):	0 0							9
Sequentially list con cause. Enter Under	lving	b. Eure to	(or as a conse	equence of	lty f):	2,cw						-	
Cause (Disease or i that initiated events resulting in death) L		c	/		0.								
, ooding in doding E	ust	Due to	(or as a conse	equence of	t):								1
	'	d										-	
IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	nonths?		birth 2☐Fe nant at time o	tal death		topic pregnan	су			23	3d. Date of o	delivery Day	Year
Part II. Other signifi	cant condition	as contributing to d	eath hut not ro	sculting in 4	the under	lvina couso d	wan in Part I		23e Did to	hacco us	e contribute	to the caus	e of death?
Tartii. Other signiii			eath but not re	Sulling in	The anger	iying cause gi	ven in Part I.						
-	VLEUM	atoid	LX Y	IM		<b></b>			1 U Ye	es 2 [	NO 3∐	Probably	4 Unknown
								_ `	24a. Was a autops perfora	med?	prior t death	to completion	lings available n of cause of
25. Was case referre	ed to medical						ne Diac-	of Death		2 <b>=</b> No	1□Y	es 2 No	2
examiner?		Hospital:	Inpatient 2[	7 EP/0	nationt C	Ot Doc Ot	la a se		(Check only on				
27. Manner of Death		28a. Date	of Injury	☐ ER/Outp 28b. Tii		28c. Inju	4724 Nu		ne 5 Reside			pecify)	
1 Matural 2 ☐ Accident	5 Pending investiga	(Mon	th, Day, Year)	Inj	jury	M 1 E	rk? ☐Yes 2 ☐ 1		-a. 5030(106 (10	- a agai y			
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	ned 28e. Place	of Injury - At ng, etc. (Spec	home, farn	m, street,	factory, office		28	8f. Location (Si	treet and	Number or	Rural Route	Number,

**Physician** /Medical Examiner

Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical Medical Certification: To

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4710 Penuing
31. Date filed (Month, Day, Year)

JUN 26 2009

and manner stated

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

me 26th 2009

09-04856 David Franklin Cohn

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

200	9 8	205	09
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		1- For State Certificate of Death	Re	g. No.			
Physician	1	1. Decedent's Name (First, Middle,Last)	Date of Deat     Month	Day Year	3. Time of Death 1209 hrs		
Medical Examine		David Franklin Cohn  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	June 19, 2	4c. County of Dea			
N		3203 Old Westminster Road Finksburg		Carroll			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 218 Months Days Hours Min	_	h(MM/DD/YYYY) 9. B Fore	ian		
Director	L	$\frac{210}{210}$ - 46 - 2084   1 $_{\overline{\mathbf{x}}}$ M 2 $_{\overline{\mathbf{F}}}$   47   Yrs.   William Bays Flouris   William	April	15,1962 °	ountry) MD		
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits		
<b>A</b>		MD Carroll Finksburg			1 Yes 2 X No		
h the Maryland 3a or 28a-f she	DIRECTO	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?		
3a or		3203 Old Westminster Pike 21048		U.S.A.			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked inher than "natural", or items 23a or 28a-fahlumstic event, the Medical Examiner must be notified at once	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Forces? 13. Was Decedent of Hispanic Origin? (S		14. Race - Ame White, etc.	erican Indian, Black,		
fter der fr., or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: W	hite		
ours a	<u> </u>	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use retired.)		16b. Kind of Busines	s/Industry		
36 in 72 h han "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	,	0			
d with ygiene the Mee	팅	12 Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N		ruction		
21215-00; uld be filed with Mental Hygiene marked nither ti c event, the Med	e D	Robert A. Cohn Eve		Randall			
MD 21215-0036 12 should be filed within 7 th and Mental Hygene. 127 is marked niher than umatic event, the Medica	-1	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or I					
and 2 s lealth a tem 27	100	Mrs. Evelyn Cohn Mother 23 Wengate Road Owing  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City			
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or nither traum		1 Burial 2 Cremation 3 Removal from State crematory or other place)  Carroll Cremation Ser 6/	22/09	Hampstead	i. MD		
altin mit. P partme porta	-	4 Donation 5 Other Specify: CATTOTT CREMITATION SET 07. 21 Stignature of Funeral Service Licensee 22. Name and Address of Facility 118					
	4	Canal Cline Funeral Home			21136 Approximate Interval		
Physician /Medical	1	<ol> <li>Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.</li> </ol>	or respiratory arre	est, snock, or near	Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (heroin) intoxication  Due to (or as a consequence of):					
		Sequentially list conditions, b					
		if any, leading to immediate cause. Enter Underlying Cause  Cuisease or injury that initiated			-0		
1 No. 8 1		events resulting in death) Last  Due to (or as a consequence of):					
execut an and al - tra	3	X UNPENDED 23a,27,28a-f,perME, g893 7/15, per fh g894 8-19-09 vt	/09 TT				
Box 68760, death certificate be executed the attending physician and d for use as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive			
	- 14	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnate at time of 5 Other (Specify)	ancy	Month	Day Year		
Box e death the attered for u	) Sic	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Specify)	<u> </u>				
that the ned by the detache	by Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?		
Division of Vital Records, P.O. has or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2, should be detachability			1 24a. Was		autopsy findings available		
cords, lav requir ha been s	Completed	·	autop	sy prior to rm <u>ed</u> ? death'	completion of cause of		
tal Roc inn: The certificate ector, page		25. Was case referred to medical 26. Place of Death (Check	1 Yes	2 No 1 🗸	Yes 2 No		
/ital	ן מֿ	overmor?		Residence 6 🗸 Ott	ner: Scene		
in of Vi		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	-	now injury occurred			
Sion ttendi death. ctor: y the fi		Natural 5 Pending Fd 6/19/09 Fd 11:50 am 1 Yes 2 K No	unk		B. J.B. J. N. J. N. J. Cib.		
Divis	21	3 Suicide 6 X Could not be determined (Specify) Specify	Oi TOWII, C	street 3203°516 tate) 3203°516 iksburg, M	Hur West Milities City		
Hospita 4 hour Funers ely fill		4 Unmicide  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	and place, and due to	the cause(s)		
H × H ŏ	Ĕ	29b. Signature and title of certifier 29c. License number		29d. Date signed (#	flonth, Day, Year)		
		Warpers Me Youll O.C.M.E.		June 20, 2009			
lacksquare	1	<ol> <li>Name and a dress of person who completed cause of death (Item 23a)</li> <li>Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD</li> </ol>	21201		, i		
Stat	te 3	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Registra		111N 2. B 2009 Cham S. Sales					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Richard Cecil Caldwell 4a. Facility Name (It not institution, give street and number) 4c. County of Death or Location of Death Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security (In vrs. last birthday) Months Days Hours Min 1₽M 2□ F 63 01/28/1946 MD 219-44-6712 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 PNo Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

21234

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

Clerk

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

USA

18. Mother's Name (First, Middle, Maiden Surname)

Nina Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Grocery Store

Director Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ent: If Item 27 is merked other than "naturel", or Items 23a or 28e-f show ortent: If Item 27 is merked other than "naturel", or items 23a or 28e-f show injury or other treumetic event, the Medical Exercitor must be notified at

Maryland 21215-0036

Baltimore,

**Physician** 

/Medical

Examiner

**Funeral** 

1 - For State Registrar

10a State

8710 Emge Road

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Namon Caldwell

19a. Informant's Name/Relationship (Type. Print)

College (1-4or 5+)

MD

Director

Funeral

à

Be Completed

ပ္

Physician /Medical **Examiner** 

Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical Examine sician and burial-trens signed by the ettending physician be detached for use as the buria Completed by has within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Pamela Dawn Elliott/Daughter 3630 Keystone Avenue Ba	altimore, N	4D 21211	
20a. Method of Disposition  1 Burial 2 In Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory Inc. 2	Jun 24	ation - City or Town,	
21. Signaffure of Funeral Service Licensee  POLY 22. Name end Address of Facility  Cremation and Funeral  8717 Green Pastures D			and 2128
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on pack line.  Immediate Cause (Final disease or condition  a Hucro Sclero to Condition		Inte	proximate erval Between set and Death
Due to (o as a consequence of):  Sequentially list conditions, if any, leading to immediate  b. Due to or as a consequence of):			
cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23	3d. Date of delivery Month Day	/ Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cerebre Vick Cillun accullung		se contribute to the ca	
	24a. Was an autopsy performed? 1 □Yes 2 ☑No	death?	findings available etion of cause of
25. Was case referred to medical examiner?			
1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ €R/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6	☐Other (Specify)	
27. Manner of Death  1	3d. Describe how injury		
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	3f. Location (Street and City or Town, State)	Number or Rural Ro	oute Number,
29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date and	place, and due to the	cause(s)
29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number		e signed (Month, Day,	
MULLIUM St. M. D3 8543  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  NEVER LA Scrugz; Mis 5001 Lock River Bindeva	nd Bult	hours, the	ery /une
31. Date filed (Month, Day, Year)  32. Registrar's Signeture  33. Aparel			

Registrar

State

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** William Gordon Dilday ,2009 1330 UNE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sandy Spring Montgonery Brooke Grove Assisted Living - Meadows 1637 If Under 24 Hrs. if Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 X M 2 □ F 85 238-28-8279 North Carolina Aug. 21,1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Clarksville **Funeral Director** MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 6818 Redberry Rd. 21029 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1944-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Federal Employee 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minton William . Jasper Dilday Ellie D. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9613 Weathered Oak Ct., Bethesda, MD 20817 Cheri A. Markey / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6/24/09 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licens M00382 20910 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical 5 days a Viral pheumonia Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown vascular dementia Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has page 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 25 No 27. Manner of Death After 1 Natural 2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined within 24 hours after devante To the Funeral Director completely filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ms attending physician 30. Name and ordress of person who completed cause of death (item 23a) (Type, Print)
Grace Brooke Huffman 18100 Stade School Road Sandy Spring, Maryland 20860 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fh g893 7-8-09 vt
State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryland / Dep	rtificate of Deal	-	Reg. No. 2	9 20512							
	Physicia	'n	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	eath Day Year	3. Time of Death							
	/Medic		Martha Elele Dorsey		June	26, 2009	3:30am M							
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death	4c. County of Dea	th							
a separat			Carroll Hospice Dove House  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)		ninster der 24 Hrs.   8, Date of Bi	Carro	thplace (State or Foreign							
ı	Funeral Director		213-42-4433 1 N X F 91 Yrs.	Months Days Hou	rs Min. (Month, D	9, Year) Co	MD							
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.	ocation			10d. Inside City Limits							
	Maryli a-f sho	tor		Windsor			1 □Yes 2 X No							
	or 28g	Direc	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?							
	ath wi	ral	3600 Hooper Road	21776		USA								
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarument must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □Yes 2√√ No Spec		14. Race - Ame Black, Whit	e, etc.							
21215-0036	72 hou	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during n	most of working	16b. Kind of Business	/Industry							
121	within ene. than "	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	Nurse		Health Ca	re							
q 7	filed Hygi Sther ent, I	Ö	17. Father's Name (First, Middle, Last)		other's Name (First, Middle									
Maryland	Mental Mental rked c	To Be	John Edwin Hood		Maude Grant									
lary	2 shou and I Is ma auma			ing Address (Street and Nu	ımber or Rural Route Num	ber, City or Town, State,	Zip Code)							
	and tealth mm 27			Hooper Road			Town State							
Baltimore,	Pages 1 Iment of h Iant: If ite		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Highland View Cemetery 6/29/2009  Berrett, MD											
Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee  Suan L. Huy + MX Xu F	TATCHT FUNERA P.O. Box 195	L'HOME & CHA Sykesville,	APEL, P.A. MD 21784								
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such	h as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death							
	/Medical Examiner		resulting in death)  a.  Due to (or an consequence of):	Julies 1	7 B.		7.00							
	CXammer	-	Sequentially list conditions, b. Durby 13 Propagation of the Consequence of the Consequen	heur (	Julie		10.80							
	outed id ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c. A worker	IL Dreed	16		2088							
Ö,	tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):											
68760,	icate t physic s the b	edical	d											
Box 6			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	elivery							
O.	that the deatl	Physician/M	in the past 12 menths?	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year							
rds, P.	Physician: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pa		tobacco use contribute Yes 2 No 3 F	the cause of death?  Probably 4 🗆 Unknown							
eco	has bee	Completed			24a. Wa	as an 24b. Were a	autopsy findings available completion of cause of							
<u>~</u>	: The cate h	Com				formed death?	_							
Vita	iclan: The certificate ector, pag	Be	25. Was case referred to medical examiner?		Place of Death (Check only	one)	1,00							
of	ing Phys n. After this of funeral dir	5	1		Nursing Home 5 Re	sidence 6 Other (Sp	ecify (PSF) 49							
on	Attending r death. ector: After by the fune	atior	1 Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2										
Division of Vital Records,	l or Atte after dea Directo	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		(Street and Number or Fown, State)	Rural Route Number,							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.											
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License numb	ber	29d. Date signed (Mor	oth, Day, Year)							
				1)630	150	6/60/09								
	6 V		30. Name and address of serson who completed cause of death (Item 23a) (Type	her Stree	+ Westpur	ister MD	21157							
	Sta	te	31. Date filed (Mogth, Day, Year)  32. Registrar's Signature	Maria Cara	. ,	7								
			CLOCKER COMMINS FOR A											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year J, 200 am 24 JUNE 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Catonsville amove Commons Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/28/1939 Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 ☐ M 2 🔼 F 69 213-36-2939 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Halethorpe Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 4803 Grenville Street 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2★ No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Boyle Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Charles C. DeSalvo (Husband) 4803 Grenville Street, Halethorpe, Maryland 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Bayview Crematory 06/25/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part . Enter the disease of shock, or heart failure. Vist Immed te Cause (Final Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Marth resulting in death) Due to (or a consequence of): Orongun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): yes, outcome of pregnancy 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director MD

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment and once.

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

Division

the Hospital or Attending Physician:

death.

The law requires that the death certificate be executed attending physician for use as the buria as

has certificate

r this certifica

After this funeral of

Director:

within 24 hours aft

To the Funeral Di

completely filled in

Examiner Physician/Medical signed by the a þ

Completed 25. Was case referred to medical examiner? Be

မ

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2 No

1 ☐ Yes

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 6 □ Could not be

and manner stated

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifler

JUN 26

31. Date filed (Month, Day,

2-No

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a, Certifier

29c. License number

29d, Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2009 22:58 Bernard Francis DeSavage, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb. 21, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Country) 1938 Massachusetts Min. Months Days Hours 1√M 2□ F Feb. 019-28-1773 71 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evantant must be reclibed at 1 ☐Yes 2☐No Director Prince George's Laurel Maryland the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or: 20707 U.S.A. 6706 Walker Branch Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 Tho 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify Specify: 9 White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Naval Surface Elementary/Secondary (0-12) College (1-4or 5+) Warfare Center Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard F. DeSavage, Sr. Helen Fedis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau spouse 6706 Walker Branch Drive Laurel, Maryland 20707 Sally A. DeSavage 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Pk 6/27/2009 Dorsey, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Se 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** Adenocarcinoma of Esophagus, Stage III Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and a betached for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 I Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Anorexia 1 X Yes 2 No 3 Probably 4 Unknown icate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □ Yes 2 🗵 🖔 1 ∐Yes 2 🖾 🔏 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 📆 1 ☐ Inpatient 2 XX R/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manuar stated. (Check only one) Medi within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

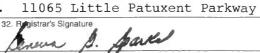
20

State Registrar John K.

31. Date filed (Month, Day, Year) 32. R

Minford, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D30573

June 25, 2009

Columbia, Maryland 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** T TOW Ida Mae Derrenberger 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner att imase If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number ( 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Year) Months 1 □ M 2 🕱 F Days Hours 219-28-4463 Director April 4, 1917 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a ~ ~ ~ ~ one. any Injury or other traumatic event. It is interested to the process. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Baltimore Maryland 1 ☐ Yes 2 🕱 No Catonsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6216 Chesworth Road 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White ۵ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Sutor Hattie Medinger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6216 Chesworth Road; Catonsville, MD 21228 Son William Derrenberger 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 6/26/2009 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Li 1630 Edmondson Avenue; Catonsville, 21228 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) PSI **Physician** one week /Medical Due to (or as a consequence of): **Examiner** one week Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending | yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) To the Hospital or Attending 1975-1988 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached in the funeral director. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1/1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIGNROlling Rd 178205 Cetursille Kodol Ferne Registrar's Signature 31. Date filed (Month, Day, Year) 62 State Registrar

DHMH 17 Rev 1/2001

ERKENBERG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar	otato or mo	,	Cert	tificate of L	Death			Reg. No.	200	9 2051
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Examine		4a. Facility Name (If not institution, gi		ì	4b. City, Town, or Location of Death BALTIMORE					4c. C	ounty of De	ath
		HARBOR			4 6 146 4 4 4	If Under 1 Year		-	Date of Bir	th	9 R	irthplace (State or Forei
Funeral			Sex 7. Age 1 M 2 Tr 82	e (In yrs. las	Yrs.	Months Days		Min.	(Month, Da)	y, Year)	(	ginia
Director	-	Usual Residence of Decedent	. 02	<u></u>				μa	.11. 0,	1921	ATT	gillia
illed within 72 hours after death with the Maryland Hygiene, Whysiene, When than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at		10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limi
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23a c	٦	1820 Spence St.,	Apt. 208			21230				USA		
SE SE	Funeral	11. Marital Status	12, Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin an, Mexican, P	n? (Specify Puerto Rica	Yes or No an, etc.)	14	<ul> <li>Race - An Black, Wh</li> </ul>	nerican Indian, iite, etc.
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h and Mental Hyg 7 Is marked other traumatic event,		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19b. Mailing Address (Street and Number or Rural Route Number)								Town, State	e, Zip Code)	
of Health and I item 27 Is ma r other trauma		Rickey Lee Baker	(Per. Rep)	2100 Wistler Ave., Baltimor								
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Department of page and in page		21. Signature of Funeral Service Lic	ensee									
으트등리						620 Wilk					MD ZI	
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ng physician and as the burial-transit	Medical	I S FRANCE										
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			l Ectopic pregnanc	cv			2:	3d. Date of Month	delivery Day Year
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by the	Physician/	9 ☐ Unknown				4.4.4	on in Doubl		230 Did	tobacco us	e contribute	e to the cause of death?
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within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination	rledge, death on and/or in	occurred at the t vestigation, in my	ime, date and opinion, death	d place, an h occurred	d due to th at the time	e cause(s) e, date and	and manne place, and	er as stated. due to the cause(s)
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> F 0		> Sheem	کن			RE	5-06	00		JUN	E 24	2009
		30. Name and address of person wh	no completed cause of	death (Item	23a) (Type,	Print) NOVER	ST 6	BALT	imo			ARYLANI
Stat	te	31. Date filed (Month, Day, Year)	a 32. Regist	rar's Signatu	ıre							
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day G Year **Physician** 10:18 AMM Beulah Francis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Elizabeth's Rehab and Nursing Halethorpe Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 M 2 TVF 02/27/1930 Director NC 246-44-6406 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the McCical Examinations is ust be notified at 1 Yes 2 No Halethorpe Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21227 3320 Benson Ave. #347 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 2 Specify: 3 ₩idowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Nonie McLean Benjamin Tuck ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rita Francis/Daughter 16 Henley Court Windsor Mill, MD 21244 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Jun 26 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Chesapeake Crematory Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives D 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician dementic /Medical Due to (or as a consequence of): Examiner ancrexic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi 0-15phag Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? HTIV 24a. Was an autopsy performed/ 1+4perlipidenia 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No 2 Accident atter death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6124109 CEND 12111615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltmore MD 21227 32. Registrar's Signature 2 b State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, per MD & 20b-c, per FH G892 6/26/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Summy Fatehyar 2. Date of Death Month Year **Physician** SUMM 0440 M 20 06 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SHOCK TRAUMA CENTER 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 20 20 1989 CA Director 621-66-2518 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 220 cm. any Injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No **Funeral Director** Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code U.S.A. 21217 307 Dolphin Street Apt 1A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married White 1 □ Yes X□ No Specify: \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student School 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgina Alvarenga Esfandiar Fatehyar 19a. Informant's Name/Relationship (Type. Print) Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Estate<sub>4</sub>Line 143 Granite Springs Drive, Esfandiar & Georgina Fatehyar 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fastside Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition Minden, N Woodlawn Burial 2 Cremation 3 Removal from State NV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, coelle 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his rt failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MASSIVE CRANIAL INSURY **Physician** /Medical Due to (or as a consequence of): 30 mw Examiner unstroz Mound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and CHITECHINA RYNNING IN MERCH COM Due to (or as a consequence of) Box 68760, attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, BIPOUAR DISORDE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2 1 ☐ Yes 25. Was case referred to medical examiner?
1 Ves 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 0407 SET INRICTED GUNSHOT WOWD 1 ☐ Yes 2 No investigation 2 Accident 06,20,2019 24 hours after death Funeral Director: 3 Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) HOME 307 DOLPHIN BALTIMORE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ed cause of death (Item 23a) (Type, Print)

SHOCK TRAIM A CHNTER, 30. Name and address of person will MONIKA 22 GRAGNESTS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 26 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Constella D. Flowers 10 15 PM JUNE 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT HOSPITAL BALT IMORE AGNES N/A Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ Months Days Hours Min 058 30 2364 72 Director 31, 1986 Georgia Aua. Usual Residence of Decedent death with the Maryland 10b County 10d Inside City Limits 10a State 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mortical Examiner must be notified at TXTYes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 S. Augusta Avenue 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 1 分 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify:Black 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 7th grade 17. Father's Name (First, Middle, Last) Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be John Doby Hattie Flowers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type. Print) 420 S. Augusta Avenue Baltimore, Maryland Patricia Simpson/Daughter Injury or other permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/29<sup>D</sup>709 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Baltimore, Maryland 22. Name and Address of FacilityChatman-Harris FuneralHome 21. Signature of Foreral Service Lio ee tans 5240 Reisterstown Rd Baltimore, Md 21215 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Physician TIZACT URINARY INFECTION PAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or injury requires that the death certificate be execute attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. □Yes 2 □ No 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ SE12URE DISCRIPER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? ITY PERTENSION 24a. Was an autopsy performed' Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1) ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2161 JUNE 21 2009 1940 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATUN 1216 ofosu MO AVENUE, BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 26 2009

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1240 PM )unc Leon Faruq 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Stuzi Baltimore Cit Ð Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 1**X**] M 2□ F Months Director 30 578-68-3768 58 01 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3714 Gwynn Oak Ave 21207 U.S.A. 12 thint Known as been 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐Yes 2X No Completed by Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 6yrs Director-Safe Streets Living Classroom 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္က Leon Awkard Irene Ireland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once. 3714 Gwynn Oak Ave, Baltimore, Md 21207 Norma B. Faruq-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 6/26/09 Woodlawn, King 21. Signature of Familial Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepstorense dry S /Medical as a consequence of): Examiner whits Sequentially list conditions, if any least by L. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical ending p 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery atten for u 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 XNo 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 XV the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Nnpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28b. Time of Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

30. Name and

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who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#9 105 c. 205 per FH C892 6/26/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 00 1914 060 Harris Foreman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Cit Maryland
5. Social Security Number General Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**75** M 2□ F Months 63 212 - 42 - 3588 Usual Residence of Decedent MD Director 10d. Inside City Limits death with the Maryland 10c. City, Town or Location ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Baltimore, AD Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 S. 12 N+A Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BIACH 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STEEL MANUFACTRES permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) FOIEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DENISE HENDRIC K 206 BAITO MJD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ANAtomy 6.44 REG 6/18/09 HANOVER MO 21076 22. Name and Address of Facility Ph. 11. PAWEA + WEA + WEAFED FS PA 21. Signature of Funeral Service Licensee Philips Well Service Licensee

2431 F. Oliver RS + BA 110

23a. lart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2431 E. OI.VERS+ BALLO MD 21213 Immediate Cause (Final disease or condition resulting in death) HOURS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine STALLE Division or Vital Records, P.O. Box 68760,实 the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1☐ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1/ Natural 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062804 06-15-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) June 19, 2009 **Physician** 7:45 Fitch Joseph Frank /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner South River Rehab Edgewater Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F 10, 1943 Maryland 66 Director 217-40-5248 Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director Marvland | N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with Hygiene. 1820 Spence St., Apt. #313 21230 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' ∏Yes 2∏ No Yes, GiveX 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. þ White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Insulator Construction l and Mental Hygiv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be finent of Health and Mental Bant: If item 27 Is marked of Vernon O'Neil Eugene Fitch Mildred Pauline Viola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John K. Fitch (Brother) 1148 West Hamburg St., Baltimore, MD 21230 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/24/09 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. Completed by 1 Probably 4 Unknown cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate etely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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s of person who completed cause of death (Item 23a) (Type, Print)

30. Name and

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year 6:15 PM M June 22, GOLDBERG OLA 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital Date of Birth (Month, Day, Year) 09/06/1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) OK Country) Days Min Months Hours 1 □ M 2 🗷 F 91 447-24-1409 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 MYes 2 No Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20010-3336 Mt. Plaesant St. NW #8 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Education College (1-4or 5+) Elementary/Secondary (0-12) Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cullen Stansell Robert Bailey Lauderdale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3336 Mt. Pleasant St. NW #8 Washington, DC 20010-Rosemary Walker/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jun 25 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910m00932 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30445 FALLURE RESPURIETORY Due to (or as a consequence of): ASPIRATION PNEUMENIA Due to for as a consequence off Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

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Department of Important: If it any Injury or o

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Goldberg, Ola

or Attending Physician:

Examiner attending physician and for use as the burial-tran Physician/Medical certificate has been signed by the rector, page 2 should be detached 2 director, Be Medical Certification: To this within 24 hours after death

To the Funeral Director:
completely filled in by the

disease or condition resulting in death) Sequentially list conditions, if any, learning to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number

State Registrar

D8868160

29d. Date signed (Month, Day, Year)

6/23/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 OLD GEORGETOWN RD BETHESDA MD MD KIMBERLY BETH ZUZAK

31. Date filed (Month, Day, Year)

JUN 26 2009

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2<u>009</u> **Physician** P M 1645 June Nicoletta Rita Galluccio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 K F Yrs. Nov. 17, 1914 New York 94 064-10-0172 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "has had Examina" is not be notified at 1 ☐ Yes 2 X No Director Potomac Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20854 11421 Cedar Ridge Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ð 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within n and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Garment Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be þe Rita DePalo ဂ္ဂ Vito Carvonaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health an Important: If item 27 is any Injury or other trau 11421 Cedar Ridge Drive, Potomac, Maryland 20854 Arlene Swanzey/Daughter 20b. Place of Disposition (Name of cemetery crematory or other place)
Calverton National Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State July 2, 2009 Calverton, New York 4 Donation 5 Dother (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature\_of Funeral Service Licensee M01548 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1. rosensis mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ectrem **Examiner** Mac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con a guence of): Examine y physician and is the burial-transit tahe Due to (or as a consequence of): persong Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 XNo 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò Heart as luxe medsone 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this Certification: To After th funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death To the Funeral Director 2 Accident the 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide \* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 0 53 691 29d. Date signed (Month, Day, Year) 29b. Signature and ti of person who completed cause of death (Item 23a) (Type, Print) Days Blud Swit 110, Rounte, mrs. 20812

State Registrar

31. Date filed (Month, Day, Year)

30. Name and ad res. 150



)9-04915 Phillip Joseph	n Gu	ada	Please Ty	pe or Print tate of Mar	t <b>in Blac</b> yland / D	Departn	nent of I	Health	ure and	All Co Menta	<b>pies /</b> I Hygi	<b>Are Leg</b> ene	ible.	nna	20525
			For State			Certific	cate of l	Death					g. No.	UUJ	
Phys Medical Exa		n/ <sup>1</sup> er	Decedent's Name (First, Midd Philip Jo	seph	Guada	gna.	Jr.				J	Date of Death Month Une 21, 2	Day 009	Year	3. Time of Death 1520 hrs
		4	a. Facility Name (if not institution 1919 Maxwell Avenue	on, give street an	d number)		46	. City, Tow Dundall		cation of E	Death		1	ounty of Deat timore Co	
Fune	201	5	. Social Security Number	6. Sex	7. Age (I	n yrs. last b	irthday)	If Under 1	l Year	If Under 2	4Hrs. 8	. Date of Birt	h(MM/DD	/YYYY) 9. Bi	irthplace (State or
Direct		- 1	218-46-8689	1X M 2	F	61	Yrs.	Months	Days	Hours	Min.	ct 29	9,19	47 C	ounMaryland
Na A		-	Jsual Residence of Decedent  0a. State 10b. County	,	10	c. City, Tow	vn or Locatio	n							10d. Inside City Limits
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after de	ner m	고	3 Widowed 4 XD	1 X Y ivorced If Yes, Giv or Dates:				Yes 2						pecify: Wh	
hours	Exami	ed L	15. Decedent's Education (Sp		grade comple ge (1-4 or 5+)	-/	a. Decedent during mo	's Usual Oo st of worki					16b. Kin	d of Business	s/industry
.36 hin 72 e.	dical	Completed	Elementary/Secondary (0-12 12 th	cone	ge (1-4 01 5+)	,	Di	isab]	Led				D	isabl	Led
5-00 led wit flygien	the Me		17. Father's Name (First, Middl	e, Last)								irst, Middle, I		urname) Gilles	spie
121 Id be fil fental	event,	B	Phil Guadagi	1a	b 1		19b. Mailino	Address							ate, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Netnell Hygiens.	matic	۵	19a. Informant's Name/Relation Kristi Hamme	erbache	paugn	ter	1959	Hase	ilme	ere 1	Road	l Dun	dalk	, Md.	. 21222
Te, No.	er tra		20a. Method of Disposition  1 Burial 2 X Cremati	on 3 Remo	val from State	crer	ce of Disposi natory or oth	er place)			June	Sate	1	-	or Town, State
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Balti Sermit. Separtr	n jury		21. Signature of Funeral Service	(). ()			22. N	ame and A	ddress	of Facility	Kacz	zorow	ski	Fune	ral Home, I
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/Maai xamii	al		failure. List only one caus Immediate Cause (Final disea	se on each line. se a. Nare	cotic	(morpl	nine)	and a	a1co	hol i	lntox	cicati	on		Death
X.G.IIII			or condition resulting in death)	Due to (o	r as a conseq	uence of):									
	ı	jē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		r as a conseq	juence of):									
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sion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be executed death.	tra	-e	T	d	DED #1	as no	ted, 2	23a,P	II,2	27,288	a-f, <sub>1</sub>	perME,	G89.	3 7/6/	og TI
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SOX (	for us	sici	1 Yes 2 No 9	lekeoue T	Pregnant at ti Unknown	me or deali	5 Ot	her (Spec	ify)						
O. E	detached	/ Phy	Part II. Other significant con	ditions contribu	ting to death	but not resu	ulting in the u	underlying	cause g	given in Par	rt I.				e to the cause of death?  Probably 4  Unknow
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.	d in by	Certification:	3 Suicide 6 X C	could not be	. Place of Inju	ury - At hom	ne, farm, stre at ho	et, factory, me	office b	ouilding, et	c. 2	28f. Location or Town, Dunda	(Street at State) 1	ng Numbero 1D	r Rural Route Number, C axweLL AVE
Hospi	To the Funeral Director: completely filled in by the		29a. Certifier	Physician: To t	he heet of my	knowledge	, death occu	irred at the	time, da	ate and pla	ace, and o	due to the ca	use(s) an	d manner as	stated. to the cause(s)
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M			30. Name and address of per					1 P	Ct== -1	Politica	OFC. ME	7 21201	•		
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Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:25 MΆ 25, 2009 June Horan Carolyn Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Towson
If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □XE Yrs 2/21/1937 Maryland 213-34-9866 Director 72 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Evants and injury or other traumatic event, It. Medical Evants and injury or other traumatic event, It. Medical Evants and injury or other traumatic event, It. Medical Evants and injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 XNo Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S. Α. 442 Grovethorn Road 21220 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker School System 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna May Wright ပ္ Alfred E. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 442 Grovethorn Road Middle River, Maryland 21220 James Thomas Horan (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6/26/ 2009 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Technol Cg 5, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (nortus **Physician** disease or condition resulting in death) ) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or strip of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed and burial-tra Due to (or as a consequence of): Box 68760, physician that the death certificate be Physician/Medical the as attending IF FEMALE: use 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 € No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year Por 5 ☐ Other (specify) o. the detached 9 Unknown <u>~</u> ģ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only on director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSCICE Hospital: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending spital o.
4 hours after dea.
\*\*neral Director: After a in by the fire atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical npletely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

6 V

State Registrar 31. Date filed (Month.

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

670/ N. Clially ST PONSON MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8,10e&f,16a&b,20a-c&22 per FH G892 6/26/09 JR State of Maryland / Department of Health and Memal Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day TY Gar MATTIE HAW NINS **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BANIMME, MD 21003 HOSPITAL SECULLES Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2**X** F 212-34-1942 <del>0ct</del> 30, 1937 South Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The My dical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1√ Yes 2 No **Funeral Director** MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1311 Pentwood Rd. 501 W. Franklin Street 21239 21201 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **AMCO** Steel Elementary/Secondary (0-12) 12 College (1-4or 5+) Steel Worker foos industry supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rov Mattison Ophelia Moore ဝ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1311 Pentwood Road Baltimore, MD Deborah Gardner/niece Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 6/26/2009 Beltsville,MD. 4 □ Donation 5 ₩ Own (Specify) in state 22. Name and Address of Facility CAFA/Stephen D. Lohrman, P.A. Stete Anatomy Board 835 W. Baltimore Streef Baltimore Streef Baltimore Streef Baltimore Streef Baltimore Streef 21. Signature of Euneral Sorvice Licensee Ronald S. Wate, Director 23a. Pat 1. Enter the diser, e, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shruk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPS15 Immediat - Lause (Final disease or - dition resulting in death) **Physician** /Medical Due to (or as a consequence of): URINARY TRAUT INFECTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CELLULITIS ABDUMINAL WALL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA; GASTRITIS GLEEDING; 24a. Was an autopsy performed? Yes 28 No HYPERTENSION; BIATRETES 1 ☐Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ones v. mombeli, no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m 2 11381 H30M - N 32. Registrar's State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) William P. Hamm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 10, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 235-36-9538 82 WV Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2√ No Carroll Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5707 White Rock Road 21784 USA 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ty∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ▼No Specify: White 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Car Hauler Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter A. Hamm Sela May Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Margaret M. Hamm (Wife) 5707 White Rock Road, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 6/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, P.A. HULL PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FIBRILLATION VENTRICULAR Due to (or as a consequence of): ISCHEMIC CARDION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ARTERY DISEASE DNARN Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL TASE 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a 28b. Time of 28d. Describe how injury occurred

Examiner the death certificate be executed and burial-tran attending physician for use as the buria by the a signed by the

Box 68760

P.0.

Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If Item 27 Is marked other any injury or other traumatic event.

**Physician** /Medical Director

Funeral

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Examiner Physician/Medical Completed

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neral Director: After this y filled in by the funeral di Certification:

To the Hospital within 24 hours a To the Funeral C

the Hospital or Attending

State Registrar 25. Was case referred to medical examiner? 1 ☐ Yes Date of Injury (Month, Day, Year) 27 Manner of Death 28c. Injury at Work? Natural 5 Pending 2 \ Accident 1 □ Yes 2 □ No investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

KHOO

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 MEMORIAL -AVE WESTMUSTERMD 2115

31. Date filed (Month, Day, Year) 32. Registrar's Signature 26 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yea Month 3: 00 A M **Physician** 2009 06 /Medical or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, 04 12 9. Birthplace (State or Foreign **Funeral** Year) Months Days XIIM 2 F Yrs 51 NC 58 Director 215-52-2457 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and be notified. Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 U.S.A. 5610 York Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Upholster Business Owner 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bettie Hill Waverly Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1711 Wadsworth Way, Baltimore, Md 21239 Delecia Pulliam-Neice 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/09 Baltimore, Md Western 21. Signature of Funeral Service 22. Name and Address of Facility 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final letustatic Cung Cancon Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unorthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann eath Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 20065210 Name and address of person who completed cause of death (Item 23a) (Type, Print) 560  $10\,\mathrm{mm}$ 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Belle Hudson Mary 2009 12:15a 23 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Bluepoint Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 01 15 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours Min 1 □ M 2 🗙 F 68 41 216-60-6930 GA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 XYes 2 No Baltimore NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 3728 Reisterstown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Docks Food Co. Assembly Line Worker 10th\_grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mattie Mae Molden Isaac Molden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21215 3728 Reisterstown Road, Doris Lawson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 6/29/09 Woodlawn, Md 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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items 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, in Medical Evan worse.

Baltimore, Maryland 21215-0036

Director

Funeral

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traumatic event, the Medical Examiner nest be notified at

the Maryland

Exami Physician/Medical certificate has been signed by the rector, page 2 should be detached \$ Completed After this certification, I Be Certification: To after death Director: / within 24 hours aft

To the Funeral Di

completely filled in

		24a. Was an autopsy performed?  1 □ Yes 2 ▼No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	ne 5 Residence 6 Other (Specify)								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)   Injury   Work?   M   1 ☐ Yes 2 ☐ No	Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred									

State

Registrar

Medical

29d. Date signed (Month, Day, Year) Juno 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith Avenue Soute 200 Baltimore MD ton

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31. Date filed (Month, Day,

29b. Signature and title of certifie

(Check only one)

32. Pegistrar's Signature

parke JUN 26 2009

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $a^{M}$ 24, 2009 9:15 John Albert Hartner, III June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 610 Sobrina Farms Court Woodbine Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min XXM 2□ F Dec. 16, 1929 MD 79 215-24-2255 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show try or other traumatic event, If a Medical Engin Mertal than confined at ury or other traumatic event, If a Medical Engin Mertal than collined at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 TX No Director Woodbine MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21797 610 Sobrina Farms Ct. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1∑Yes 2☐No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2. No Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Ward John Albert Hartner, Jr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 610 Sobrina Farms Ct., Woodbine, MD 21797 Edwina A. Hartner/ Wife Date 25, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June Department of Important: If it any injury or o 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State West Arundel Crem. 2009 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses Ken Stiles M01053 MD20707 313 Talbott Ave., Laurel, 23a. Fort1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** week a pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 years su ranuclear palsy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events iner Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye a in the past 12 months? 5 Other (specify) P.0. been signed by the should be detached 1 □Yes 2 □No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s autopsy page performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ₩ No or Attending Physician; 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? After t 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1. Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

within 24 hours after deau..

To the Funeral Director: Af To the Hospital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Dr., Suite 275, Olney, MD 20832 MD, Edward P. Taubman, 31. Date filed (Month, Day, Year) Registrar's Signature

and manner stated.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 4:05 Physician June 20 2000 Marie Ann Henry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore City Birthplace (State or Foreign Country)
 KY 8. Date of Birth (Month, Day, Year) 3-13-1922 If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 Ϊ 👍 87 Director 220-18-8306 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, it a Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21239 1646 Gleneagle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 → Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Mills Senie Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Barts Court, Lutherville, MD 21093 Deborah Nesbitt-Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any injury or of once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 6-22-09 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LEKEBILAL ZWOZKS Physician VASCULAR resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical y the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 □Yes 2 No 2 🗆 No certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpati ပ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. the death certificate be P.O. Division of Vital Records, I or Attending Physician: after death. Director: After this certifica completely filled in by the e Hospital ο 24 hours aff e Funeral Di

Baltimore, Maryland 21215-0036

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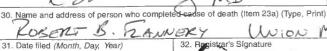
Medical

-OSERI 31. Date filed (Month, Day, State Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certific



Wion BMCRIAL 29d. Date signed (Month, Day, Year)

HOSPITAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AT 2438946 C-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04904 State of Maryland / Department of Health and Mental Hygiene Zy- Kee Holland Certificate of Death 1- For State Reg. No Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0902 hrs June 21, 2009 **Medical Examiner** emmani 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore**  St. Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director 1**X**M 2 21 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 28a-f show Director 10g. Citizen of What Country? s 23a or 28a-10e. Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Yes 2 No specify: If Yes, Give Yea Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Itygiene Divorced Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ other than "r MD 21215-0036 110 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIVIT Be 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is kham Kal 20b. Place of Disposition (Name of cemetery, . Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State 6-27-09 Department or Important: I BAHIMORE Other Specify Donation 5 22. Name and Address of Facility Ph, / ( i / Signature of Funeral Service Licensee . 01.0 ER S+BA/to Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death Sudden Unexplained Death in Infancy (SUDI) xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f per me g894 8-20-09 vt AMENDED X UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✓ No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? 1 V Yes Yes 2 e Hospital or Attending Physician: Ti n 24 hours after death. e Funeral Director: After this certifica tetely filled in by the funeral director, pa 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other Nursing Home 5 Residence 6 2 FR/Outpatient 3 Inpatient 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: Natural Yes 2X No Pending 6-21-09 unknown unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 508 S. Wickham Rd. 3 6 X Could not be Suicide Baltimore, 24 hours a (Specify) found at home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. June 22, 2009 30. Name and address of person who completed cause of death (Item 23a)

OKARA

DHMH 17 Rev 1/2001 OCMF 2006

Registra

OCME

Donna M. Vincenti, MD

26

ORIGINAL

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland / Dep	artment of H				and and an	and the second s
			Registrar  1. Decedent's Name (First, Middle, Las	t)		Timeate of E	Journ	2. Date of De	Reg. No.	UU 5	3. Time of Death
	Physicia	an						June 2	Day	Year	6:15 A M
	/Medic		Catherine Conger  4a. Facility Name (If not institution, give			4b City Town or	Location of Death	ounc 2		y of Death	
1	Examin	er	Potomac Valley Nu			Rockvil				gomei	cv
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		054-14-9349	□м 2🖾 F	90 Yrs.	Months Days	Hours Min.	Feb. 21,	1919	New	York
	D.		Usual Residence of Decedent								tod Incide City Limite
	urytar show	_	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits  1 □Yes 2 No
	8a-f	Director	Maryland   Montgome	ery	Potomac				10g. Citizen of	14/h at Cau	
	ith th	ä	10e. Street and Number			10f. Zip Code					
	s 238	eral	12509 Northline C		in 110	20854	ionania Origin? (Sn	ocify Vas or No	United		can Indian,
	item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕱 N	ver in U.S.	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bla	ack, White,	
36	I', or	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Speci	ify: Wh:	ite
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Evan, he in ust be maithed at		15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occup	ation	lna	16b. Kind of E	Business/Ir	ndustry
218	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)		life.	e kind of work done of DO NOT use retired	during most of work d)	ing			
21	filed within Hygiene. other than '	Som	, , , , , , , , , , , , , , , , , , , ,	College (1-4or 5- 5+	Home	maker			Own Ho		
nd	be filed value Hygin doubler	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	,	, Maiden Surna	me)	
yla	2 should be f n and Mental I is marked of raumatic eve	၉	Edward Augustus C				Mary Wha				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Merital Hygiene at them 27 is marked other train "natural", or items 23a or 28a-f show item 27 is marked other train.		19a. Informant's Name/Relationship (7			ing Address <i>(Str</i> eet) 9 Northli					
e,	and Health		Mary Kate Losman/ 20a. Method of Disposition	Daughter				Date	20c. Location		
وّ	nt of I		1X Burial 2 ☐ Cremation 3 ☐		1	osition (Name of ematory or other place	ce)				
Baltimore,	it. Pa irtmei irtant injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen			ational Ceme					virginia
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Furieral Service Licen	11	101548   R	22. Name and Addresobert A. Pum 00 West Monts	phrey Funer gomery Aveni	al Home/R ue, Rockv	lockville ille, Mar	yland	20850
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	the death. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition		NGEST	7.15 4	MART	PALL	VRE		Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	101	77-1				
	Examiner		Sequentially list conditions	b			***				
\	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
کم	ecute and -trans	хаш	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):						
8760,	death certificate be executed e attending physician and d for use as the burial-transit			Due to (or as i	consequence or,						
387	icate phys s the	dic	•	d							
9 x	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. [	Date of deli	very
Вох	death atter	Physician/Medical	in the past 12 months?	4 Pregnant at		☐ Ectopic pregnanc ☐ Other (specify) _	у 			Month	Day Year
Ö.	t the c by the ached	hysi	9 Unknown	9 Unknown			A1114				
о, С	The law requires that the date has been signed by the page 2 should be detached	by P	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the	underlying cause giv	ren in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
ī	quire en sig rutd b							1 🗆	Yes 202 No	3 ☐ Pro	obably 4 Unknown
မင္ပ	e law re has be ie 2 sho	Completed						24a. Was			topsy findings available completion of cause of
æ	The page	mo;						perf 1 □ Yes	ormed? 2 No	death? 1 ∐Yes	
ita,	ician: The certificate ector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
Ž	Physic this o	된	1 Yes 2 DNo		nt 2 ER/Outpati		Nursing H		sidence 6 🗆 C		cify)
n O	Attending Physician: r death. ector: After this certific. by the funeral director, I	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Dat	ry 28b. Time v, Year) Injury	Wor	'k?	28d. Describe	how injury occ	urred	
sio	tend leath tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No	204 Location	(Ctroot and Nu	mhor or Pu	ral Route Number,
=	in ite	Certification:	4 Homicide determined	building, etc	iry - At home, farm, s c. <i>(Sp</i> ec <i>ify)</i>	treet, factory, office		City or To	own, State)	nuer or nu	rai rioute Number,
_	Hospital 24 hours 2 Funeral I		29a. Certifier 1 Certifying Ph	yslclan: To the best	of mv knowledge, de	ath occurred at the ti	ime, date and place	, and due to th	e cause(s) and	manner as	s stated.
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examone)	niner: On the basis o and manner sta	f examination and/or	investigation, in my	opinion, death occu	rred at the time	e, date and plac	e, and due	to the cause(s)
	To the within the complete of	Me	29b. Signature and title of certifier	1		29c. Licens			29d. Date sig		
				Jone 1	cus	000	25172		61	231	09
	15		30. Name and address of person who					D 1	*11. 14	D 200	250
			Truong Bao, M.I	32 Registre	Molecular	: Drive, S	uite 206	, KOCKV	тте, м	ע ע ע	150
	Sta Registr		JUN 2 6 2009	Server )	1. park						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8&9 Per FH G893 7/17/09 JH State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jun **Physician** Johnson 4:46 22 2009 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSE paltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 2 / 3 901/91933 5. Social Security Number **Funeral** 10 M 20 F Days Hours Min. 216-30-239 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ahow 77 is marked other than "natural", or items 23s or 28s-f shov traumatic avent. Its Madical Examinar must be nutified at 1 Yes 2 No Kandallstown MD Rallimor e Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Horseman 15A 21133 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2☑No Yes, Give 1 Never Married 2 Married Specify: BLOCK 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Secondary (0112) College (1-4or 5+) WOCKER grande 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 Horseman Ct. Kardallstour MDZ1133 Jutlaw/Distr f Health Jeanette 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Methodrof Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Greene Juneral Srus 21. Signature of Funeral Service Licensee allehu andallstorn, WDZ1133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple myeloma >6 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical lhe th use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? signed by the atte 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by chronic failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🔊 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No thromboeu to penia Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient 2 EF Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 3 DOA Certification; To funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06/22/2009 D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 URAIYA BEWUM BELVEDERE AVENUE, BALTIMORE WI MD -31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 08 Grace Dhason Lup /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner altimore Daryland Greneral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day **Funeral** 1 M 2 F 84 Yrs Months Days Hours Min 217-20-0430 Director MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD LIMOVE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Allendale Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes 2 \_\_No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify \$ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (9-12) College (1-4or 5+) social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thompson

19a. Informant's Name/Relationship (Type. Print) Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3815 B4field Rd. Baltimore Dron Wynn Mason/ , MD Z1201 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Ballinge. 06-26-09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Varenn C. Greene funoral Sps. 21. Signature/of Funeral Service Licensee Kandallstown, MB 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failule. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final hRonic Physician disease or condition resulting in death) /Medical Due to (or as a consequen , of) Examiner lex Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. the detached signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy certificate perform 2 No of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 □Yes 2 □ No a er death 2 Accident investigation the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in b. 4 Homicide Hospital Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 7 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year)

Registrar

State

(Type, Print)

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's

ionatur

			1 = For Amend Iter	ns 23aPt1,	Marylan 25,8 pe	d/Depa T dry Cer	rtment of b tificate of	lealth and 6726 <i>7</i> 09 Death	Mental Hy	giene Reg. No.	009	20537
			1. Decedent's Name (First, Middle						2. Date of De		Year	3. Time of Death
	Physici /Medio		Harry L. Ken	nedy					June 1	8,200	9	0359Hr <sup>M</sup>
3	Examir		4a. Facility Name (If not institution	, give street and numb	ber)		4b. City, Town, or		ath	4c. 0	County of Death	
			Harford Memo				Havre de		rs R Date of Ri	A2/12	Harfor	olana (State or Foreign
	Funeral		5. Social Security Number	6. Sex 7	. Age ( <i>in yr</i> s. <i>i</i>	Yrs.	Months Days	Hours Mi	n. (Month, Da	ay, Year)	1923 We	place (State or Foreign intry)
	Director		236-24-4946 Usual Residence of Decedent						1 001 00	- y - y	1343 110	VII SIMIA
	Maryland -f ehow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
		ctol	Md. H	arford		Jo	ppa					1 ☐ Yes 2Ã No
5	death with the ms 23e or 28s	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?
こ	ath w 23a	rai	2618 Frankliny				21085	0.1-1-0	(0# . V#)	. 1	USA 4. Race - Amer	iona Indian
8		une	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pue	erto Rican, etc.)	o-   '	Black, White	
J 9800	rs after I', or its	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Z Yes 2 If Yes, Give Year or Dat	les: 1943-	-1945	1 ☐ Yes 2 🛣 No	Specify:			Specify: Wh	ite
, O	72 hou natura		15. Deceden	's Education		16a, Deced	dent's Usual Occup	ation		16b. Kin	d of Business/l	ndustry .
25	트 - 목	Completed	(Specify only highes Elementary/Secondary (0-12)	ct grade completed) College (1-4	4or 5+)	life. I	kind of work done DO NOT use retired	1)	vorking			
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a de	be file tal Hy d oth	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's N	ame (First, Middle	a, Maiden S	Sumame)	
enned arvland 2	should be filed withing Mental Hygiene. In marked other than umatic event, the Mental Control of the Mental Con	၉	Clyde Kennedy						ie Hudne			
Kenned Maryland 24	2 st and and le n		19a. Informant's Name/Relations				ng Address (Street					
			Eleanor A. Ket	nnedy Sp	ouse	-	B Frankli	nville	Rd. Jopp.		. 21085 cation - City or 1	
Baltimore.	600		1 ← Burial 2 ☐ Cremation			emetery, crer	natory or other plac				Station	
를	permit. Pag Depentment Important: i any injury o		4 ☐ Donation 5 ☐ Other (S		Ga		Forest Name and Addre	c =	9,2009			7.0
Ba	Dep Imp eny		21. Signature de Vision de Vision				9705 Bela		Schimune			
6			23a, Part1. Enter the disease, or	complications that car	used the death					_	MQ. 21	Approximate
	Dhysisian		shock, or heart failure. List Immediate Cause (Final	only one cause onea	ch line.	R	S ALCO	face (	Distores	5	domes	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to to	r as a consequ	uence of):	52 bira	Tory 1	UNTRE	3 04	ndrane	THORES
	Examiner			. 7	Cute	. Δ	Saura	rate		11/2	5	minutes
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseq	uence of):	7	7//	PROVED BY MEDIC	AL EXAMIN	ER	3.31129
H	executed in and ial-transit	Examiner	that initiated events	с			/	1/1/	DON'ED BY MEDI	JAC -		
0	be exe		resulting in death) Last	Due to (o	r as a conseq	uence of):	/	CHATFICATION	Tr.			
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~ ×	requires that the death certificate een signed by the attending phys nouid be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome	ome of presses	nov		1			0.4 D 4 d. l'	
59 Box	eath certifi attending for use as	ian	23b. Was decedent pregnant in the past 12 poinths?	1 ☐ Live bir	th 2 ☐ Feta nt at time of d	Ideath 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deli Month	very Day Year
m 0	t the de by the	Physician/M	1 □ Yes 2 No 9 □ Unknown	9 Unknow		eath J		- Agrana	4			
0 9	ires that the signed by	돈	Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ds,	quires n sign	d by							_ 1 🗆	Yes 2	No 3□Pro	obably 4 Unknown
g Record		Completed							24a. Wa	s an	24b. Were au	topsy findings available
<b>9</b> 8	The law ate has b page 2 si	E		- · · · · · · · · · · · · · · · · · · ·					- auto peri 1 ☐ Yes	opsy formed? 2 No	death?	completion of cause of
		BeC	25. Was case referred to medical		7.11.22			26. Place of D	Death (Check only	4	10.00	20.00
∞ <del>°</del> >		TO E	examiner? 1 X Yes	Hospital: 1 ☐ In	patient 2X	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	sidence 6	S ☐Other (Spec	cify)
_			27. Manner of Death  1. Natural 5 Pendin	28a. Date of (Month	Injury , Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe	how injury	y occurred	
Sign C	Attending r death.	atic	2 ☐ Accident investig	ation				Yes 2 □ No				
	spital or Att ours after d neral Direct filled in by I	Certification:	3 Suicide 6 Could determ	inad 200. Place	of Injury - At ho g, etc. (Specif	ome, farm, str y)	eet, factory, office			(Street and own, State)		ıral Route Number,
104		Medical (	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the base	sis of examina	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date and pla opinion, death o	ace, and due to the courred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
,	To the Howithin 24 h To the Full completely	Me	29b. Signature and title of certifie				29c. Licens	se number		29d. Date	e signed (Monti	, Day, Year)
	⊢ s ⊢ ō		) W	00 1	N.O.		DO	0621	793		6/18/	2009
Q			30. Name and address of per a	o completed cause	of death (Iten	1 23a) (Tvoe	1		1 -	1		
44			Matthews	rordan	MD.	50	15.0	MION A	tie, b	tour	des	race MO
23.44	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	eruti		11-14-1		-		21078
0.	Regist	ar	JUN 2 6 20	19 agner	J.	par						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 23aPtI, II per dr. 2892.06/36/09dhb
Registrar Registrar Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month : 47AM THEODORE JUNE 2009 22 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HUSPITAL BALTIMORE
If Under 1 Year If Under 24 Hrs. 8. Date GOOD SAMARITAN BALTIMORE CITY 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Min. Days 1**X**M 2□ F Months Hours 88 August 29,1920 Maryland 218-05-9856 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1XYes 2 No N/A Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 USA 624 St. Dunstons Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Supply Sales Representative 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John W. Knach Anna Jankiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 624 St. Dunstons Rd. Baltimore, Md. 21212 Mrs. Jane Knach/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-27-09 Baltimore, Md. St. Mary Govans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final TRA disease or condition resulting in death) Due to (or as a consequence of) Pneumonia Sequentially list conditions, Due to for as a consequence of : cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy Congestive Heart Failure 2 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No 27. Manner of Death

1 Natural

2 Accident Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending PhysIclan: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760,

burial-transit attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached 24 hours after death Funeral Director: filled in by the

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

Be

2

Physician/Medical Examiner

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Be Completed

Certification: To

29a. Certifier

(Check only one)

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, The Medical Examinations to roffled at once.

Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

State Registrar

Medical within 2

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

JUNE 22 2009

MEKONEN YA SU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Raven Boukvara

Melconen MD 5601 FYASU 31. Date filed (Month, Day, Year) JUN 2 6 2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 2009 **Physician** 3:14 ам VIRGIN LEAVITT JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE GENESIS HERITAGE HEALTHCARE DUNDALK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 07/02/1921 9. Birthplace (State or Foreign 6. Sex Funeral Months Days Hours Min 1 □ M 2**X** F Maryland 87 Director 219-07-2287 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h Count 10c. City. Town or Location Department of Health and Mental Hygiene. important: in items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantine must be reatified at once. MD BALTIMORE **ESSEX** 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 U.S.A. 1813 OLD EASTERN AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: If Yes, Give Year or Dates: WWII Specify: WHITE ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSPECTOR BETHLEHAM STEEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSENAUER MICHAEL **ELENORA** (HAAS) ೭ 19a. Informant's Name/Relationship (Type. Print) NIECE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRONWYN ROSENAUER/IN-LAW EAST MAIN STREET NEW MARKET, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SACRED HEART JESUS 6-29-09 DUNDALK, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): TRUCTIVE PULMONARY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed EMENTIA burial-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of physician s the burial TNEMI Physician/Medical aftending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion o cause of death?

1 □ Yes 2 1 No 24a. Was an certificate has the rector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No dir 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Pretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Signature and title of certifier D27188 6-26-09

e, Print)
ar Two Place Dundala Mo 21222 ate filed (Month, Day, State 6 Registrar

(enn	eth Alle	en Le		, Jr. S1 1- For State Registrar	ate of Maryla		artment of rtificate of		Mental I		eg. No. 20	09 20540
Med	Phy ical Ex	sicia camii	ın/	Decedent's Name (First, Midd Kenneth Alle	n Lewis,					2. Date of Dea Month June 23, 2	th Day Year 2009	UOTTRIS
				4a. Facility Name (if not institution 8359 Jumpers Hole R		imber)	4	b. City, Town, or L Pasadena	ocation of Dea	ith	4c. County of Anne Art	
	Fund Direct			5. Social Security Number 220-84-7750	6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24H Hours M	1	th(MM/DD/YYYY) 8, 1964	9. Birthplace (State or Foreign Country) Marylan
1		f show any once,	ō		Arundel		Town or Location					10d. Inside City Limits 1 Yes 2 X No
	the Mary	23a or 28a-f sho notified at once	Director	10e. Street and Number 8359 Jumpers	Hole Road			10f. Zip Code 211	108	1	Og. Citizen of What United	at Country? States
	more, MID 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Menial Hygiene.	ral", or items 2.	by Funeral		larried Armed Fo	2 X No	If Ye	s, specify Cuban, Yes 2 X No	Mexican, Puer specify:		White,	White
	<b>JU36</b> within 72 hours iene.	er than "natu Medical Exam	mpleted	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12 yrs.	College (1			s Usual Occupation st of working life.  Machinis	DO NOT use r S <b>t</b>	etired)	16b. Kind of Bus	
	<b>Z1Z15-0036</b> uld be filed within 7 Mental Hygiene.	narked oth event, the	8	<ol> <li>Father's Name (First, Middle Kenneth Allen</li> <li>Informant's Name/Relations</li> </ol>	Lewis, S	r.	19h Mailing		Alva	me (First, Middle, I McMilli	on	n, State, Zip Code)
5	MD shound 2 shou	item 27 is r traumatic	٦	Mrs. Dawn E. I			1001		Road G	len Have	n, MD 2	1061 City or Town, State
3	<b>Baltimore</b> , permit. Pages 1 an Department of Hea	<b>≒</b>		1 X Burial 2 Cremation 4 Donation 5 Other S 21 Signature of Funeral Service	pecify:	om State	crematory or other	er place) L Cemetei	cy 6/	27/2009	Brook1	yn, Maryland
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	Physic /Medi `xami	ical		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on Cach line. a. <b>Diphen</b>		ne into			or respiratory an	est, silver, of flea	Between Onset and Death
	72	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	c	consequence o						
	be executed	vsician and burial - transit	edical	XUNPENDED	d AMENDED	23a,27,	28a-f,pe	erME, g89	94 8/12	/09 TT		
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0	es that the	signed by the	<u> څ</u>	Part II. Other significant condit	tions contributing to	death but not r	esulting in the ur	nderlying cause gi	ven in Part I.			oute to the cause of death?  Probably 4  Unknown
	OT VITAI KECOFOS, 18 Physician: The law require	has been 2 should	Completed							24a. Was autop perfo	psy pr rmed? de	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
1,734-1	VITAI 1ysician:	를 등	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 №	Hospital:	npatient 2	ER/Outpatient		of Death (Chec Other Mur		Residence 6 ✓	Other: Scene
4	on or nding Pl	or: After the funeral	ioi.	27. Manner of Death  1 Natural 5 Pend	ding	Day,Year)	28b. Time of In	1	at Work?	1	how injury occurre	
	or Att	Jin by	Certification:	3 X Suicide 6 Coul	origunori		Fd 6:00 ome, farm, street residence	, factory, office bu	ilding, etc.		Street and Numbe	r or Rural Route Number, City Jumpers Hole R
5	To the Hospital within 24 hours	completely f	Medical C	10.100.101	hysician: To the bes miner:On the basis of and manner s	of examination a						
	)  - * +	3	Me	29b. Signature and title of certific		8 Th.	mid	29c. License O.C.M		OME	29d. Date signe June 23, 20	d (Month, Day, Year) 009
R	5 V	,		<ol> <li>Name and address of person Theodore M. King, Jr.</li> </ol>		nt Medical E		111 Penn Stre	eet, Baltimo	ore, MD 2120	1	
	Re	Sta egisti		31. Date filed (Month, Day, Year)		istrar's Signatu		11				

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of	Maryland		rtment <i>tificate</i>			d Menta		iene <sub>eg. N</sub> 2. () (	19	20541
E	Physicia		1. Decedent's Name (First, Middle Miranda S.R. I				-			2. Dat Mo Jun	e of Deat nth		00 <sup>Year</sup>	3. Time of Death 8:40 A M
	/Medic Examin		4a. Facility Name (If not institution National Luther	_	per)		4b. City, To	own, or Lo					y of Death	
	Funeral Director		5. Social Security Number 556-45-8359	6. Sex 7 1 □ M 2 ☑ F	Age (In yrs. las.	t birthday) Yrs.	If Under 1 Months		Under 24 Hours N	Hrs. 8. Dat Min. (Mo Apr	e of Birth onth, Day, il 8	, <sup>Yea</sup> r) ,1917	9. Birth Con Chir	nplace (State or Foreign untry) 1a
	aryland show	or	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montg	omerv	10c. City, 7	Town or Lo	cation	Rock	ville			10d. Inside City Limits  ty∐Yes 2 ☐ No		
	with the N a or 28a-f	Direct	Maryland Montg  10e. Street and Number  9701 Veirs Driv				10f. Zip C	ode 208	 50		1	Og. Citizen of		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  In marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Footloof Examination to notified at any injury or other traumatic event, the Footloof Examination and once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr  3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Ford	Mo		Was Decede fYes, specif 1 □Yes 2		anic Origin Mexican, P	n? (Specify Ye Puerto Rican,	s or No- etc.)	14. Ra Bl	ack, White	rican Indian, e, etc. sian
0500-61717	within 72 hou jene. r <b>than "natura</b> in mode.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)			(Give life. i	dent's Usual kind of work DO NOT use ager	done dur retired)	ing most of			16b. Kind of l Busine Admini	ss stra	
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, Mary	and 2 shousalth and Natural Natura Na		19a. Informant's Name/Relations Ingrid Wang/ N			5034	South	erns	tar T		, Co	lumbia	, Mar	ryland 21044
anmore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		cen	netery, crei Lgome,	osition (Name matory or oth ry Lum, I	ner piace)		une 26 2009			sda,	Maryland
Dail	permit. Departimont import any inj		21. Signature of Funeral Service	hit	M01498	B B B	2. Name and etheso etheso	da-Ch da, M	of Facility N Nevy ( Sary 1	Robert Chase and 208	lnc.	ump re 7557	y un Wisc	era Fome/ onsin Avenue
	Physician /Medical		23a. Part 1. Euro the disease, or shock, or eart failure. List Immediate Cause (Final disease or condition resulting in death)	_a(	used the doubth. th line. or as a conseque	n	ter the mode	of dying,	such as ca	ardiac or resp	iratory ar	rest,		Interval Between Onset and Death
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	or as a conseque									,
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Y < I	Physicia this certi al directo	To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital: 1 □ I	npatient 2 E			Other	4 Nurs	sing Home	ō ☐ Resi			ecify)
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To	3 Suicide 6 Could	gation	of Injury - At hong, etc. (Specify)	28b. Time of Injury ne, farm, st	М		es 2∐N	28f. Le	ocation (	Street and Nu		Rural Route Number,
<u>S</u>	spital or /		4   Hornicide	na Physician: To the	hest of my know	vledne dea	ith occurred	at the tim	e, date and	d place, and d	lue to the	wn, State) cause(s) and	l manner	as stated.
	To the Hospital within 24 hours and the Funeral I completely filled	Medical	(Check only 2 Medical one)  29b. Signature and title of certific	Examiner: On the ba	asis of examinati	on and/or i	nvestigation.	, in my op	inion, death	h occurred at	the time,	date and place	ce, and du	nth, Day, Year)
			harles	W. Ker	sh	1	$ \rangle$	217	26			June	224	1,2009
	3		30. Name and address of persor Charles W. Ka		0/000	D 1 1	D	d, Da	amascı	us, Ma	ry1a	d 2087	72	
	Sta	ate	31. Date filed (Month, Day, Year JUN 2 6 200	Deneva 32 R	26033 egistra/s Signa	give								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ALLEN LAND 19, TUNE 2009 12:20p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE CENTER TOWSON If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 3–20–1953 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) If Unde **Funeral** Days Hours Months Min MARYLAND 1 M 2 □ F 56 214-58-6269 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ira Medicel Eco. intermatic an ordinal aury or other traumatic event, Ira Medicel Eco. intermatic autoriting at 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a, State or items 23a or 28a-f show instrumst be notified at 1 →Yes 2 □ No **Funeral Director** MD. N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 610 E. 41st ST. 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Completed by BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGEMENT ENGINEER JOHNS HOPKINS UNIVERSITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUSSELL LAND MATTIE M. MOBLEY ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LAND (WIFE) 41st ST. BALTIMORE, MARYLAND 21218 Department of Health Important: If item 27 any Injury or other to once. MARSHA D. 610 E. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 6-25-2009 BALTIMORE, MARYLAND vie densee JONATHAN HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final diseas or ondition resulting in death) month ANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be execute sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the buria' Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗹 Yes 2 🗌 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The 1 ☐ Yes 2 No 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA After this c 1 ☐ Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 ☐ Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide hours after 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 19, 2009 LUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. Charles Ste Backs. and Ze 20%

State Registrar 0

Year)

31. Date filed (Month, Day,

701 6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month 1335 PM **Physician** THOMAS WAYNE MORGAN JUNE 3 2009 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MASHINGTON NEDICAL CILEN BURNIE ENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days MD 212.42.9612 62 JUNE 21, 1947 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show ns 23a or 28a-f short and a short 1 ☐ Yes 2 ☐ No Director **GLEN BURNIE** MD ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 405 3rd AVE SW 21061 USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items it any Injury or other traumatic event, the Medical Event mention once. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No li**Ye**s, Give Year or Dates: **VIETNAM** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XXIo ģ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CONTRACTOR 12 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) HAROLD LEON MORGAN MARGARET ELIZABETH DENNIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KIFE 405 3rd AVE SW CLEN BURNIE, MD 21061 MARILYN MORGAN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State BAYVIEW CREMATORY INC. JUNE 24, 2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Livens 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. K. CREGORY FINK M01T48 426 CRAIN HWY SW CLEN BURNIE, MD 21061 Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tellural List only one cause in each line. Approximate Interval Between Onset and Death 23a. Part Immediate Cause (Fin 1) disease or Indition resulting in 11th) **Physician** /Medical tr (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to lonas a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 NNo 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural
Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year) JUN 26

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

3

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:55 PM M June 22 2009 Dennis Dwight Mohr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Heritage Center Genesis Heath Care Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F 07/19/1942 MD Director 218-40-8391 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director M Dundalk Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 23a 7232 German Hill Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 2100 Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify White à 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland Cup Corp. d 2 should be filed within; th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Elaine Day Thomas Julius Mohr Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau 1701 Charlotte Avenue Baltimore, MD 21224 Sandra Kosmaczewski/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages ' Jun 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 101443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ASCULAR ACUIDENT be executed burial-transit and physician a the burial Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 212No certificate 2 1 ☐ Yes 1 ☐ Yes Physiclan: director, 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation atural Hospital or Attending 1 ☐ Yes 2 ☐ No Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours a Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only 24 one) and manner stated the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

26

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8,15,& 19a, per FH 9893 7/9/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 8:15 **Physician** ам Gretchen Taylor Millson 24, 2009 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 8603 Springvale Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) June 30, 1938 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 569-52-9624 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20910 USA 8603 Springvale Road 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items Black, White, etc. hours after 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education 72 (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Museums Art Historian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Griswold Taylor Dorothy Baumgarten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
John J. Millson
John T. Millson, husbar Pages 1 and 2 ment of Health a 8603 Springvale Rd. Silver Spring, MD 20910 husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ō Beltsville, MD 6/25/2009 permit. Page Department ( Important: If any injury or Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) M01539 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 leu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aterial Thrombosis of Lower Extremities **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) certificate be executed burial-transit Hypertensive Arteriosclerotic Heart Disease and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ Hepatic Encephalopathy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Late Effect of Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Pulmonary Hypertension 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 24, 2009 Robert H. D0055522 Tuano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H Gerard; 1500 Forest Glen Road Silver Spring, MD 20910 32 Registrar's Signature State Registrar

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 22, 2009 5:50 June Ellen H. Mosher /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Lutherville Baltimore Brightwood Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 F 1944 June 20, Maryland 216-42-6389 65 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Bel Air MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1118 Spalding Drive Unit D Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Lucent Technologies 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John James Heinstadt Eleanor Loretta Powers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1118 Spalding Drive Unit D; Bel Air, MD 21014 Charles H. Mosher husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/24/09 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Prvice ice 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final oronam **Physician** disease or condition resulting in death) /Medical Examiner gestre Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner Abrillation Yarrays med be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA ို 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? Certification: After 1 Hospital or Attending 24 hours after death. 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 06-23-09 J. HIRPARA MO 30. Name and address operson who completed cause of death (Item 23a) (Type, Print) osler Drive TOWSUN

Registrar

State

31. Date filed (Month, Day, Year)

JUN 26 2009

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20549 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:50pm DWARI 3 NUT 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE JOHNS HOPKINS BAYUIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-14-1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 ☐ F Months PA 215-18-3304 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1X Yes 2 □ No Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3012 Dunmurry Road 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: WWII 1 ∐Yes 2 ∐KNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel 12 Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Casimir Macinskas Frances Radavicinte 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Macin - Daughter 3012 Dunmurry Rd., Dundalk, MD 21222 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Bayview Crematory 6-25-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA MEEK disease or condition resulting in death) Due to (or as a consequence of): CORONARY ARTERY DISEASE 20 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 20 YEARS HYPERTENSION resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner attending physician and for use as the burial-trar Box 68760, requires that the death certificate be signed by the a P.O. Division of Vital Records, cate has page 2 s certificate

Examine Physician/Medical þ Completed e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, Be Certification: To completely filled in by

**Physician** 

/Medical

**Examiner** 

Director

Funeral

à

Completed

Funeral

Director

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

"natural", or if

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event the second of the s

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

To the I within 2 To the I

Medical

1 Natural 2 Accident 3 Suicide 4 Homicide

> 29a. Certifier (Check only

5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

RES-000

29d. Date signed (Month, Day, Year) SUNT 242009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

M.D. 4940 EASTERN A VENUE BALTIMORE, MD S. DAUISON

31. Date filed (Month, Day, Year)



Registrar

09-04706 Carsun Morris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 20550

		1- For State Registrar	Certificate of L	Death	Reg	g. No.	2 2000
Physici Jedical Exam		1. Decedent's Name (First, Middle, Last)  Carson Morr	, /5		2. Date of Death Month June 13, 20	Day Year	3. Time of Death 1045 hrs
		4a. Facility Name (if not institution, give street and num 2600 Oakley Avenue	iber) 4b.	City, Town, or Location of D		4c. County of Death	
Funeral Director		4.		If Under 1 Year If Under 2 Months Days Hours			thplace (State or Foreign untry)
Director		063-48-4604 1 M 2 F Usual Residence of Decedent	53 Yrs.		//-/	-1955 No	nth Canding
э апу		10a. State 10b. County	10c. City, Town or Location	. •			10d. Inside City Limits  1 Yes 2 No
Aaryland 28a-f show 1.at once.	Director	10e. Street and Number		HMORE 10f. Zip Code	10	g. Citizen of What Cour	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygers 1 Fish are 1 Fish and Menter Han "matural", or items 23a or 28a-f she lattic event, the Medical Examiner must be notified at once		2600 OAKley A		21215		US	A
death wi r items	uneral	11. Marital Status  1 Never Married 2 Married 1. Yes		Decedent of Hispanic Origin? , specify Cuban, Mexican, Pu		White, etc.	can Indian, Black,
er,	by F	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade)	T-MINE TO	es 2 No specify: Usual Occupation (Give kind	of work done	Specify: 6L	ack
6 72 hou in "nat	leted	Elementary/Secondary (0-12) College (1-	4 or 5+) during mos	t of working life. DO NOT use	e retired)		Employed
5-0036 led within 7 Hygiene lother than	ompl	17. Father's Name (First, Middle, Last)	· La	nd Scrper	lame (First, Middle, M		Liprogea
21215-( uld be filed a Mental Hygi marked oth	BeC	Charence Mor	RRIS	Chr	istine	Willia	_
E 0 2 0 2	은	19a. Informant's Name/Relationship (Type, Print) Wetty Morris		Address (Street and Number			( Zip Code)
nore, hages I and nt of Healtlit: If item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from	20b. Place of Disposition	on (Name of cemetery, r place)	Date /	20c. Location - City or	
.E a e # 5		4 Donation 5 Other Specify: 21. Signature of Fund 1 Service Livensee	1 Ut 210	n Cemelery me and Address of Ficility	4/19/1920	Balto.	Ind . La Charol
Balt permit. Departr Import injury		Jak Challer	16	39 N. BR	oadway	Balto.1	Nd.
Physician /Medical		28a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.			ac or respirator arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclero	etic Cardiovascular Disea consequence of):	ase			Deall
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a condition)	onsequence of):				
	caminer	C. Disease or injury that initiated events resulting in death) Last C. Due to (or as a context of the context o	onsequence of):				
xecuted and transi	sal Exa	d					
760, ficate be execut g physician and the burial - tra	/Medical		em#5perFH,G892	,6/26/09,WS		23d. Date of delivery	,
20 20		23b. Was decedent pregnant in the past 12 months?	at at time of death	death 3 Ectopic pro	egnancy		Day Year
BO) he death the attu	Physician	1 Yes 2 No 9 Unknown 9 Unknow	'n		100-0-111		
i, P.O. ires that th signed by I be detach	ā	Part II. Other significant conditions contributing to o	leath but not resulting in the und	derlying cause given in Part I.		pacco use contribute to	
Records,  The law requir ficate has been si	Completed				24a. Was a autops		topsy findings available completion of cause of
tal Reco ician: The law certificate has	Som					ned? death?	es 2 No
Vital ysicians his certi	a	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 In In	patient 2 ER/Outpatient	26. Place of Death (Ch		Residence 6 🗸 Other	r: Scene
Division of Vital tal or Attending Physician: Is after death. al Director: After this certiled in by the funeral director	on: To	27. Manner of Death 28a. Date of (Month, I	f Injury 28b. Time of Inju			ow injury occurred	
risior r Attend er death irector: by the	Certification:	2 Accident Investigation 28e Place	of Injury - At home, farm, street,	1 Yes 2 No		treet and Number or Ru	ıral Route Number, City
Div spital o hours aff neral D	Serti	4 Homicide determined (Specify)			or Town, St	ate)	- 20
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifuting the hours after death.  Within 24 hours after death.  The Fauneral Inector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  2 ✓ Medical Examiner: On the basis of and manner sta	examination and/or investigation				
A P P S	<b>§</b>	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	nth, Day, Year)
<b>4</b>		30. Name and address of person who completed cause	of death (Item 23a)	O.C.M.E.		June 19, 2009	
		Carol Allan, MD Assistant Medical E	xaminer 111 Penn St	reet, Baltimore, MD 2	1201		
S Regis		31. Date filed (Month, Day, Year)  JUN 2 6 2009	istrar's Signature				

09-04971	
Suzi Marilyr	Morris

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 20551

•		1- For State Registrar	o or maryland?	Certificate c	f Death		Reg		07 2000
Physic	ian/	Decedent's Name (First, Middle,	_ast)				Date of Death     Month     I	Day Year	3. Time of Death
ledical Exan	niner	Suzi Marilyn M	orris				June 23, 20	09	2223 hrs
		4a. Facility Name (if not institution,	give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Dear Baltimore Co	
		5207 Redhill Way			Rosedale	1	To a section of the s		1
Funera		Social Security Number     6	. Sex 7. Age (	In yrs. last birthday)	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	_	(MM/DD/YYYY) 9. B Fore	ign
Directo	r	085-46-5892	M 2 XF	51 Y		Trouis Limit	10/11/	1957   c	ountry) CA
		Usual Residence of Decedent							10d. Inside City Limits
v any		10a. State 10b. County		Oc. City, Town or Loca					1 Yes 2 X No
faryland 28a-f show	5	MD Balti	more	Rose	edale		· · ·		
Maryl 28a-l	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho	<u> </u>	5207 Redhill Wa	У		21237			USA	
h with	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13. W	as Decedent of Hisp Yes, specify Cuban,	oanic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
deatl or ite	E	1 X Never Married 2 Mar	1 Yes 2 X	No				C****D] -	-le
safter ral",	<u>a</u>		ced If Yes, Give Year or Dates:		Yes 2 X No ent's Usual Occupati		ork done	Specify:Bla	
hour natu	P	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5+	during	most of working life.	DO NOT use reti	red)	TOD! YAIRG OF BUSINESS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
36 in 72 han '	Completed	Elementary/Secondary (0-12)	4		tive Admin	nistrato	r	State Dep	t.
4 with	Į Ę	17. Father's Name (First, Middle, L		Висси	1	18.Mother's Name			
215-0036 be filed within 7 ntal Hygiene. riked other than	Be	Robert Edward M				Evelyn	Atkinsor	1	
212 ould b	I S	19a. Informant's Name/Relationshi		19b. Mail	ng Address (Street	t and Number or I	Rural Route Numb	oer, City or Town, Sta	ite, Zip Code)
MD d 2 sho Ith and n 27 is		Evelyn Fountair	/ Mother	24 B	erkshire 1	Lane Pal	m Coast,	FL 32137	
e, Pand and Healt item		20a. Method of Disposition			osition (Name of cen	netery,	Date	20c. Location - City	or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she		1 Burial 2 Cremation		9	Park Cremato	200V 6 2	5.2009	Riverdale.	MD
ortan	5	4 Donation 5 Other Specification of Funeral Service L		22	Name and Address	of Facility			D 3
Dep Dep		John of m	Winama	L A	517 Dark 1	Haidhte	λτω Ralt	Directors,	21215
Physicia	n	23a Part I. Enter the disease, or o	omplications that caused th	ne death. Do not ente	r the mode of dying,	such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medica	il 🔻	failure. List only one cause of Immediate Cause (Final disease	a. Contact Gunshot	Wound of Ches	st				Death
xamine		or condition resulting in death)	Due to (or as a conseq						
	١.	Sequentially list conditions,	b						
	Examine	if any, leading to immediate cause. Enter underlying Cause	Due to (or as a conseq	(uence of):					
	Ţ μέχ	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	quence of):					
cuted	<u> </u>		d						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and	Medical	UNPENDED	AMENDED	^	_				
760, icate be	S S		23c. If yes, outcome		5-1-1-1	Ectopic pregn	ancy	23d. Date of delive Month	very Day Year
Sox 687 leath certific e attending	Physician	past 12 months?	1 Live birth Pregnant at ti	ma of dooth	Fetal death 3   Other (Specify)	Copic pregn	arroy	incine.	Su)
Box e death c the atten	ysic	1 Yes 2 No 9 🗸 Unkr		0	Other (opening)			Ī	
cords, P.O. B law requires that the de	Ph		ns contributing to death	but not resulting in th	e underlying cause (	given in Part I.			to the cause of death?
P.O.	d by						1 Yes	2 V No 3 P	Probably 4 Unknown
ds,	Completed						24a. Was a		autopsy findings available to completion of cause of
COT law I has t	ldu u						perfor	med? death	1?
tal Rection: The certificate		25. Was case referred to medical			36 Place	e of Death (Check	1 Yes	2 No 1 🗸	res 2 140
ician ician s cert	B B	examiner?	Hospital: 1 Inpatien	nt 2 ER/Outpati		Other		Residence 6 🗸 Ot	her: Scene
of Vital Records, ing Physician: The law requir Physician: The law required this certificate has been as	on: To Be Con	27 Manner of Death	28a Date of Injur	v 28b Time		ry at Work?		now injury occurred	
<b>~</b> ± · ~ ·	<u>o</u>   E	1 Natural 5 Pendi	ng FOUND: Day,Ye	FOUND:	1_	Yes 2 V No	Subject sho	t self	
Signature Atter	by the	2 Accident Inves	Jun 23, 2009	2200 hrs ury - At home, farm, s	treet, factory, office I	building, etc.			Rural Route Number, City
Division tal or Attendir rs after death.	Certification:	3 Suicide 6 Could determ	not be (Specify) Sing		•		or Town, S 5207 Redhill V	<sup>state)</sup> Way, Rosedale, Mi	D
ie on			vsician: To the best of my	knowledge, death or	curred at the time, d	late and place, ar	d due to the caus	se(s) and manner as s	stated.
the P	Medical	(Check only one) 2 Medical Exar	niner: On the basis of exam	nination and/or invest	gation, in my opinior	n, death occurred	at the time, date	and place, and due to	the cause(s)
P = 1	ଞ <b>୍ଚ</b>  ଞ୍ଚ	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (	Month, Day, Year)
		(ande	Here Oa.	1	O.C.	M.E.		June 24, 2009	)
		30. Name and address of person	who completed cause of de	eath (Item 23a)			*	J	
			sistant Medical Exam	niner 111 Pen	n Street, Baltim	ore, MD 212	01		
	State	31. Date filed (Month, Day, Year)	32. Registrar		Med		_		
Poo	istra	IIIV & C OOD	a Senewa	B. Bar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tem 20b per 1h 8892 6-30-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🔏 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12057 M 22 Day **Physician** UNE Rose Anna Napier /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner ANME BURNIE 7. Age (In yrs. last birthday) GENTER SARTIMOIZE WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Feb. 12,1915 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 🗓 F 94 MD 220-03-9081 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, Ita Nation Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Anne Arundel MD Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 740 Evergreen Road 21144 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hat Maker Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Be John Cleman Wood Mary Eller Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Mrs. Rosalie Adams/Daughter 740 Evergreen Road Severn MD 21144 20c. Location - City or Town, State Date e 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' June 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation PA Services 1 2nd Ave. SW Glen Brunie, MD 21061 21. Sonature of Funeral Service Licensee '1 2nd Ave. SW Glen Brunie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FULMONARY OBEREUTINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): attending physician for use as the burial Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 □Yes 2 ☑No 2 □No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral c 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 46 1 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person whi Glen Brune

State Registrar 31. Date filed (Month, Day,

3501

92 B 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A M Margaret Ann Nelson June 25 2009 2:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** 1 □ M 2 🗓 F New York 124-40-3211 57 July 1, 1951 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre Medical Examinar must be routhed at 1 X Yes 2 □ No Director Maryland Montgomery Takoma Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number mit. Pages 1 and 2 should be filed within 72 hours after death with i partment of Health and Mental Hygiene. Dordant if flem 27 is marked other than "hatural", or items 23a or injury or other traumatic event 20912 7401 Piney Branch Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1971-86 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🗓 No Specify Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Gustuv Nelson Dorothy Mary Brennan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7401 Piney Branch Road Takoma Park, Maryland 20912 Margarita Covarrubias/Partner 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition July 1, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Pinelawn, New York 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn Memorial Park 2009 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01546 300 West Montgomery Avenue Roc 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01546 Immediate Cause (Final Months Metastatic Ovarian Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Months Extensive Peritoneal Carcinomatosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed Months Ascites sician and burlal-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burla Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2 No ed by the detached i 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number parich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 1500 Forest Glen Road, Silver Spring, Maryland 20910 Barbara Supanich, 31. Date filed (Month, Day, Year)

JUN 2 6 2009 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:51 AM ames 20 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arundel Glen Baltimore Washington Medical Burnie Anne Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1**X**□ M 2□ F 73 183-26-7968 March 1,1936 PADirector Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It's Medical Examinat reveal be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 722 Pamela Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣No Specify: White þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tam Preparer H&R Block 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy O'Leary Cecilia B. Hills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Timothy T. O'Leary/Son 14919 York Road Sparks Glencoe, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Servcies, PA 1 2nd SW Ave. Glen Burnie, MD 21061 MO1121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hours disease or condition resulting in death) Jepsu /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown icate has been significate page 2 should b 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy 1 ☐ Yes 2 XNo 1 ☐ Yes 2 🔼 No spital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number D0067186 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jungwon DI University of Maryland Med. Ctr. Balto. MD 32. Registrar Signat State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JUNE 20. 2009 15:36 DOROTHY ANN PALMER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **HARFORD** UPPER CHESAPEAKE MEDICAL CENTER BEL AIR Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 □ M 25€ F New York MAY 22, 1929 Director 102-22-7723 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 601 E. MacPhail Road Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 🔑 No Specify: Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) Antique Sales <u> Antique Dealer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melba Christian Davis Gerald M. Hart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 601 E. MacPhail Road, Bel Air, MD 21014 James E. Palmer/ Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 6-24-09 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 us 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure Secondary to: Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to as a consequence of): Severe Mitral Regurgitation Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Atheroscleration Disease. the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After or Attending 1 Natural 5 ☐ Pending investigation thin 24 hours alter con-o the Funeral Director: Af-completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

DHMH 17 Rev 1/2001

State

Registrar

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29b. Signature and title of certifier

Kevia Lynch 31. Date filed (Month, Day, Year)

29c. License number

035012

The sapeake Dr. Bel tir, mo 21014

6/22/2009

and\_manner stated.

ss of person who completed cause of death (Item 23a) (Type, Print)

m. D. 500 Upper

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

			1 - Registrar Certificate of Death		leg. No. 200	9 20556
	Dhusisi		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		George Joseph Panzer		20, 2009	2 :00A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	
and the			Oak Crest Village Care Ctr. Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltin	nore rthplace (State or Foreign
h	Funeral Director		216-01-9431  Usual Residence of Decedent  O. Sex Mary 1. Age (m yrs. last bill may)  Yrs. Months Days Hours Min.	7-14-	(, Year) C	ountry)
	land ow		10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
	Mary a-f sh	tor	MD Baltimore Baltimore			1 □Yes 2 No
	th the	Sire	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What C	ountry?
	death with the Maryland ims 23a or 28a-f show rinust be notified at	Funeral Director	8830 Walther Blvd., Unit 227 21234		USA	
	items	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spin Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
35	hours after tural", or ite	by F	1 □ Never Married 2 □ Married 1 ② Yes 2 □ No If Yes, Give 3 □ Will Will 1 □ Yes 2 ☑ No Specify: Year or Dates: WWII		Specify: V	Nhite
5-0036		ted	15. Decedent's Education 16a. Decedent's Usual Occupation	ng l	16b. Kind of Business	s/Industry
7	within 72 iene. than "na he Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ng		
2			12 Associate Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name	(Eiret Middle		Electric
yland	the filed antal Hyge ed other; event,	Be		a Auft	waiden damame,	
	d 2 should th and Mer 7 is marke traumatic	은	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Run		r. City or Town, State	Zip Code)
Mar	7 is		Nancy McHugh - Daughter 12 Northford Way, I			
ē,	一工を参		20a. Method of Disposition 20b. Place of Disposition (Name of competers cramators or other place)	Date	20c. Location - City of	
altimore,	nit. Pages artment of ortant: If it Injury or o		1 □ Burial 2 XCremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Bayview Crematory 6-22	2-09 I	Baltimore	e, MD
Ball	permit. Departi Importa any Inj		21. Signature of uneral Service Licensee  22. Name and Address of Facility Bra PA, 2134 Willow	adley-	Ashton Fu	neralHome
1			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval Between
and the same	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition  ONE UMDNI  ONE  ONE  ONE  ONE  ONE  ONE  ONE  O			Onset and Death
	/Medical		resulting in death)  a. tue to (or as e consequence of):	^		2 007-5
-32.	Examiner	U	a. The to (or as a consequence of):  Chronic Obstructive. Full work if any, leading to immediate  a. The to (or as a consequence of):  Chronic Obstructive. Full work  Due to (or as a consequence of):	ary H	iscase	> Syrs-
_	led sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	)		
-8-	execut and al-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
6876U	rificate be executed ig physician and as the burial-transit		d			
ğ	rtificat ng phy as th	ledical				
X Q Q	death cert e attendin d for use a	an/l	IF FEMALE: 23c. If yes, outcome of pregnancy   1		23d. Date of d	elivery Day Year
	he des the at	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown		WOTET	Day
٠.	that the	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Kecords	w requires that the de s been signed by the should be detached	d by		126	′es 2□ No 3□	Probably 4 ☐ Unknown
၀ ပ	2 % 2	Completed		24a. Was a		autopsy findings available o completion of cause of
_	sictan: The law certificate has birector, page 2 sl	mo		perfor	rmed? death'	
Vital	Physician: this certific	Be (	25. Was case referred to medical examiner?			
5	Physi this c al dire	ု	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho		dence 6 ☐ Other (Si	pecify)
ב	aling F	ion	1 Natural 5 Pending (Month, Day, Year) Injury Work?	28d. Describe h	now injury occurred	
DIVISION	Attending r death. ector: After by the funer	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S	Street and Number or	Rural Route Number,
$\leq$	al or / s after I Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Toʻu	vn, State)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	To the within Го the хотрік	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	.1 1-1		> quotive Treis CRot R043580		6/211	09
•	11+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JUSTINE Preis CRNP 8832 Walther Blue	1. Ba	Hp.mD- =	31234-
	Sta		31 Date filed (Month Day Year) 32, registrar's Signature		0	
	Registr	ar	JUN 2 6 2009 Anna B. Anna			

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** June Pamnani Motilal Bhagwandas /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Village 19221 Seneca Ridge Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) October 5, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1**X** M 2□ F 033-46-1287 Yrs. October 75 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location items 23a or 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Evaruiner rust be notified at Director Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 20886 19221 Seneca Ridge Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 16e Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Item 27 is marked other than amy Injury or other traumatic event, Inc. M. 2008. Elementary/Secondary (0-12) Professor 17. Father's Name (First, Middle, Last) Be Bhagwandas S. Pamnani Lachmi B. Bajaj 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Renuka M. Pamnani / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) June 24, 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01305 23a. Part 1. Wiscons III Avertue, Detriesda, Fra 23a. Part 1. Wiscons III Avertue, Detriesda, Part 1. Wiscons III Avertue, Detriesda, Detriesda, Detriesda, Detriesda, Detriesda, Detrie Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Carcinoid Tumor /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> Be Completed

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

Wan wolakum no

Ross C. Donehower, M.D.

28a. Date of Injury (Month, Day, Year)

and manner stated

DIRECTOR

32. Registrar's Signature

MEDICALDNOUGH

10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States Race - American Indian. Black, White, etc. Specify: Asian Indian 16b. Kind of Business/Industry University 18. Mother's Name (First, Middle, Maiden Surname) 19221 Seneca Ridge Court, Montgomery Village, MD 20886 20c. Location - City or Town, State Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death 11 years 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1🔼 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) June 23, 2009 401 North Broadway, Baltimore, Maryland 21287

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3. Time of Death

12:32 PM

9. Birthplace (State or Foreign

Pakistan

Reg. No.

22,

Year) 1933

2009

Montgomery

4c. County of Death

V

in 24 hours after deau...
The Funeral Director: Af

within 2 To the I

State Registrar

Certification: To

Medical

25. Was case referred to medical examiner?

1∐Yes 2XiNo

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

29c. License number

D23675

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

IK UNK		S	tate of Mar		Depart	ment o	f Heal	th and			Are Legiene	gibie		
		1- For State Registrar			Certi	ficate o	f Deat	h				eg. No.	201	19 205
Physicia	31.17	Decedent's Name (First, Midd									2. Date of Dea Month	Day	Year	3. Time of Death 1802 hrs
edical Exami	ner	Allisha Nico				<del></del>					June 10, 2		County of Day	
À		4a. Facility Name (if not instituti 4003 Biddison Lane	on, give street and	inumber)			46. City, Baltir		ocation of	Death		40	. County of Dea	a(ri
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last	birthday)		er 1 Year			8. Date of Bir	th(MM/		Birthplace (State or eign
Director		168-66-4808	1 M 2X	F		23 Yrs	Month 6.	s Days	Hours	Min.	Oct.	14,	1985	Country) PA.
	ŀ	Usual Residence of Decedent	1						·					
/ any		10a. State 10b. County		1	Oc. City, To	own or Loca	tion							10d. Inside City Limit
and show	5	Maryland			Balt	imor	e							1 X Yes 2 N
Maryi 28a-1 d at o	Director	10e. Street and Number					10f. Zip	Code			1	0g. Citi:	zen of What Co	ountry?
the last or otified		4003 Biddson	Lane				21	206				U.	S.A.	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status	A ====	Decedent E	ver in U.S.						cify Yes or No lican, etc.)	)-	14. Race - Am White, etc	erican Indian, Black,
or ite	튑		1 Ye	es 2 🔀	No						,			
after	þ		vorced If Yes, Give or Dates:				Yes 2					_	Specify: B1	
hour:		15. Decedent's Education (Sp				6a. Deceder during n			DO NOT I			160. 1	Kind of Busines	ss/industry
36 in 72 han " lical	plet	Elementary/Secondary (0-12	Colleg	je (1-4 or 5-		Stud	ent					$  _{\mathbf{E}_{\ell}}$	ducati	on
with giene her t	Completed	1 2 17. Father's Name (First, Middle	a Last)	<u> </u>		- Doda		11	8.Mother's	s Name (	First, Middle,			
115. al Hy red of		Larry N. Rob						- 1		,	Royst		,	
212 212 uld be Ment mark	0	19a. Informant's Name/Relation		)		19b. Mailir	g Addres	s (Street	and Numi	ber or Ru	ural Route Nu	mber, C	ity or Town, St	ate, Zip Code) 1914
AD 2 sho 27 is mati	F	Marlene Milt	on/Moth	ner		437	Cask	ev S	Stre	et.I	Philad	deli	ohia.P	ennsylvan
e, hand Health item		20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Na	me of cerr			Date	20c.	Location - City	or Town, State
ages ] nt of ] other		1 Burial 2 X Crematic		al from Stat	Bay	matory or o	cre Cre	mato	orv	6-24	1-09	Ba	ltimor	e,Marylan
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	. 4	4 Donation 5 Other 3 21. Signature of Funeral Service							of Facility					Chapel, P
Ba Depring		michael P. 2.	andle-			- 1				riai				
Physician /Medical		Muchaul F. Maryland 16009Harford Road, Baltimore, Maryland 2121  23a. Part I. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease  a. Sharp Force Injuries  16009Harford Road, Baltimore, Maryland 2121  Approximate Interval Between Onset and Death												
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Sharp Force injuries  Due to (or as a consequence of):												
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		as a conse	quence of):									
	Examiner	(Disease or injury that initiated events resulting in death) Last	c	as a conse	quence of):			_						
ecuted and - transit			d											
be ex sician	dic	UNPENDED	AMEND	ED									M	
Division of Vital Records, P.O. Box 68760, within 4 hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 ✓ U	the 1 Li	es, outcom ive birth regnant at t		2 F	etal death		Ectopic	pregnar	псу	23	d. Date of deliving Month	very Day Year
s, P.O. Bc nires that the des signed by the a	Physicia	Part II. Other significant cond	9 0	nknown ng to death	but not res	ulting in the	underlyin	g cause g	iven in Pa	rt I.	23e. Did	tobacco	use contribute	to the cause of death?
P.C	by										1 Ye	s 2	<b>/</b> No 3 ☐ F	Probably 4 Unknow
of Vital Records, P. ing Physician: The law requires the Properties of the Propertie	Completed										24a. Was			autopsy findings availal
cords,	du											ormed?	death	
tal Recian: The	ပ္ပ										1 ✔ Yes	21	No 1 🗸	Yes 2 No
tal Rec	Be	25. Was case referred to medic examiner?	al Hospital:	<b>—</b>		70.4 "			of Death ( Other <sub>4</sub>	-		ا ا	6 2 0	Shari Caona
of Vid ling Physic After this	ို	1 ✓ Yes 2 No 27. Manner of Death		Inpatier Date of Injur		R/Outpatier		50,1	y at Work		Home 5 28d. Describe	_	ence 6 🗸 O	ther: Scene
n of ding Ph	o	1 Notural	nding FOL	Jonth, Day,Ye	par)	FOUND:	ii ijai y		es 2		Subject as:			
Division tal or Attendir rs after death. al Director: A	Certification:		estigation Jun	10, 2009		1750 hrs ne, farm, str	not factor				28f Location	/Stroot	and Number of	Rural Route Number, C
Divi	Ę	det	uld not be			/ Rowhou		y, office b	ullullig, et	- 1	or Town.	State)	e, Baltimore,	
ospita hours unera ly fille		4 Momicide	1000					o timo do	to and ala	- 1				
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying one) 2 Medical Ex	Physician: To the aminer:On the ba	asis of exam	knowledge nination and	, ueath occi d/or investiga	ation, in m	ie ume, da ny opinion,	death oc	curred at	the time, date	and pl	ace, and due to	o the cause(s)
To t with To t	Med	29b. Signature and title of certification	and manr	ner stated.				c. License						Month, Day, Year)
	_	N. 20	1/mn/	7 ~				0.0.1					ne 11, 2009	
		alor	1744	UV	noth /lar n	~		2.011					., 2530	
ZV			ssistant Medi		niner 1	I11 Penn		Baltimo	ore, MD	21201				
	tate	31. Date filed (Month, Day, Year	)	2. Registrar	's Signature	pair	01							

DHMH 17 Rev 1/2001 OCME 2006 09-04955 Kristir

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 20559

R	State of Maryla	Certificate of Dea	n	Reg. No.	3. Time of Death
Physician/	e <b>gistrar</b> . Decedent's Name (First, Middle,Last)		N/	ate of Death onth Day Ine 23, 2009	Year 1318 hrs
Examiner	Kristen Anne Storme	r	Town, or Location of Death	lne 23, 2009	County of Death
	a. Facility Name (if not institution, give street and no		an City		orcester
	Coastral Highway at 33rd Street		der 1 Year   If Under 24Hrs.   8.	Date of Birth(MM/DI	D/YYYY) 9. Birthplace (State or
Funeral	5. Social Security Number 6. Sex	Mon	Min.	arch4,19	Foreign
Director	181-66-7403 1 M 2XF	23 Yrs.		arch4,13	900 ]
	Usual Residence of Decedent	10c. City, Town or Location			10d. Inside City Limits
any	10a. State 10b. County				1 X Yes 2 No
show	PA. Blair	Hollidaysbu	rg ip Code	10g. Citiz	en of What Country?
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number			U.S	Δ
the M tiffed Dir	1409 Walnut Street		dent of Hispanic Origin? (Speci		14. Race - American Indian, Black,
r death with the Maryland or items 23a or 28a-f show must be notified at once.	1 . Iviantai Otatoo	ecedent Ever in U.S. 13. Was Dece Forces? 15 Yes, spe	ecify Cuban, Mexican, Puerto Ric	an, etc.)	White, etc.
leath r iten	1 X Never Married 2 Married 1 Yes	2 X No	2 X No specify:		Specify:White
il", o	3 Widowed 4 Divorced If Yes, Give Y	Table San deette Her	ISL Occupation (Give kind of world		(ind of Business/Industry
n "natural" al Examine	15. Decedent's Education (Specify only highest gr	during most of	working life. DO NOT use retired	,	
ral E	Elementar yroddon y y	(1-4 or 5+) Photogra	opher		otography
21215-0036 nult be filed within 7 Mental Hygiene. marked other than ite event, the Medica	4	111000320	18.Mother's Name (F	irst, Middle, Maiden	Surname)
Hygi	17. Father's Name (First, Middle, Last)  John D. Stormer		Karen A.	Gapske	
121 d be fil lental I arked avent,	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Add	ess (Street and Number or Rui	al Route Number, C	ity or Town, State, Zip Code)   6 6 4
D 21 should and Me ' is ma artic ev	John&Karen Stormer/	Parents 1409 Wa	alnut Street	Hollida	ysburg, Pennsylv Location - City or Town, State
MD 2 sho	20a Method of Disposition	20b. Place of Disposition			
of He rit	1 N Burial 2 Cremation 3 Remova	Alto Reste		30-09 Al	toona, Pennsylva
Page ment tant:	4 Donation 5 Other Specify:	22. Name	and Address of Facility Mai	czullo F	uneral Chapel, P
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at onceinjury or other traumatic event, the Medical Examiner must be notified at onceinjury or other traumatic event, the Medical Examiner must be notified at onceinjury or other traumatic event, the Medical Examiner must be notified at onceinjury or other traumatic event, the Medical Examiner must be notified at onceinjury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be not the model of the must be not the must b	21. Signature of Funeral Service Licensee	600	orr fored Door	a Daltim	ore Maryland212
	23a. Part I. Enter the disease, or conditions the	at caused the death. Do not enter the m	ode of dying, such as cardiac or	respiratory arrest, sh	Approximate Interv Between Onset an
Physician edical	failure. List only one cause on each line.				Death
aminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Due to (or	as a consequence of):			
	b.				
ō	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):			
nsit	cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of):			
lisit ed	events resulting in death) Last Due to (or				
cath certificate be executed attending physician and for use as the burial - transit	UNPENDED AMEND	DED			
O, e be e ysicia buria	23c. If	yes, outcome of pregnancy			23d. Date of delivery  Month Day Year
376 ificate ig phy is the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ive birth 2 Fetal		ncy	Month Day real
x 68	past 12 months?	Pregnant at time of death 5 Other	(Specify)		
Box 6876( e death certificate the attending phy ted for use as the b	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 the past 11. Other significant conditions contributed to the past 12. The past 11. Other significant conditions contributed to the past 12. Other si	Unknown	erlying cause given in Part I.		co use contribute to the cause of death?
ires that the de a signed by the detached f		ing to death but not resulting in the same	, 5	1 Yes 2	No 3 Probably 4 Unknow
0 = 501				24a. Was an	24b. Were autopsy findings avail- prior to completion of cause
sig lbe	B			autopsy performe	d? death?
rds, I				1 🗸 Yes 2	No 1 Yes 2 No
e law requires te has been sig	6				
Records, In: The law requires inficate has been sign, page 2 should be	25. Was case referred to medical		26.Place of Death (Check		-idense 6 V Other: Scene
fital Records, F sician: The law requires is certificate has been significate by the significate has been significated.	examiner? Hospital:	I III III III III III III III III III	Other <sub>4</sub> Nursi	ng Home 5 Re	sidence 6 Other: Scene
of Vital Records, F 9 Physician: The law requires 1 Fer this certificate has been signeral director, page 2 should be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Date of Injury 28b. Time of Inju	DOA Other Nursi  Nursi  28c. Injury at Work?	ng Home 5 Re 28d. Describe how Operator of bil	
on of Vital Records, F nding Physician: The law requires th: r: After this certificate has been sig re funeral director, page 2 should be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Date of Injury (Month Day Year) n 23, 2009	DOA Other Nursi  28c. Injury at Work?  1 Yes 2 No	28d. Describe how Operator of bill	vinjury occurred ke that collided with a motor
ision of Vital Records, F Attending Physician: The law requires er death. rector: After this certificate has been sign by the funeral director, page 2 should be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Date of Injury 28b. Time of Inju	DOA Other Nursi  28c. Injury at Work?  1 Yes 2 No	28d. Describe how Operator of bill vehicle	vinjury occurred ke that collided with a motor
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Division of Vital Records, F tospital or Attending Physician: The law requires 4 hours after death.  "uneral Director: After this certificate has been signified in by the funeral director, page 2 should be	25. Was case reteriled to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending  1  Accident  Investigation  3  Suicide 6  Could not be determined (S)	Date of Injury (Morth Day Year) 1318 hrs  28b. Time of Injury 1318 hrs  28b. Time of Injury 1318 hrs  28b. Time of Injury 1318 hrs	DOA Other Nursi  Nursi  28c. Injury at Work?  1 Yes 2 No  factory, office building, etc.	28d. Describe now Operator of bill vehicle 28f. Location (Stre- or Town, Stat 33rd Street / Co.	vinjury occurred ke that collided with a motor eet and Number or Rural Route Number, e) astral Highway, Ocean City, Md
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryla			of Health <i>of Death</i>			_	2000	20560
			Registrar  1. Decedent's Name (First, Middle, Las	t)		incare	or beatr		2. Date of Dea		2005	3. Time of Death
	Physicia /Medic		Grace	Evelyn	Simmor	ıs			Month June 22	Day 20	Year <b>09</b>	1:00 a <sup>M</sup>
-	Examin		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location		0 0110		County of Death	1.00 a
			Dove House				stmins				Carro	
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex	s. last birthday) Yrs.		Year If Unde Days Hours		8. Date of Birt (Month, Da	th y, Year)	Cou	place (State or Foreign intry)
			Usual Residence of Decedent	01				1	March 8	5, 19	720	MD
	ryland how	_	10a. State 10b. County	10c. (	City, Town or Lo	cation						10d. Inside City Limits
	e Ma 8a-f s	Director	MD Carroll		F	inksbu	rg					1 ☐ Yes 2 📉 No
	vith th		10e. Street and Number			10f. Zip C					en of What Cou	ntry?
	eath v	Funeral	2455 Baltimore	2 BLvd 12. Was Decedent Ever in	11.6 12.1	Non Decedor	21048	riging (Cne	noify Vac or No		U.S.A. 4. Race - Ameri	ioon Indian
36	be filed within 72 hours after death with the Maryland Hydjene.  do other than "natural", or items 23a or 28a-f show event, the modern Fraction or not be notified at		1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1		f Yes, specify I □ Yes 2			ecify Yes or No Rican, etc.)		Black, White, Specify:	etc.
21215-0036	2 hour	Completed by	15. Decedent's Ed	Year or Dates:	16a, Dece	dent's Usual (	Occupation			16b. Kin	WI ad of Business/Ir	hite
212	hin 72 e. an "në	plet	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of work of NOT use	done durina mo	st of worki	ng	70011111	.a 51 Basii 1990/ II	,,,,,,
6.4	filed with Hygiene ther the	Com	12	Oollege (1-401 5+)		Housev	vife				Own Home	e
nd	be filed tal Hyg d other event, I	Be	17. Father's Name (First, Middle, Last)				18. Moti	her's Name	(First, Middle,	Maiden S	Surname)	
ryla	hould be nd Menta marked matic ev	유	Richard E. Maso						e Mech			
Ma	d 2 sh Ith an 17 is r traur		19a. Informant's Name/Relationship (7 Kathi L. Gittere	Daughter							Town, State, Zi	
ē,	s 1 and 2 s of Health a Item 27 is other trau		20a. Method of Disposition		Place of Dispo				ate		eation - City or T	21136 own, State
E O	Pagee nent o nt: If I	- 3	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom state	cemetery, cren vergreeı			6/25	/09	Fin	kshurg.	Maryland
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licen								town Ro	
<u> </u>	8 <b>3 5 6</b>	0 (1	14X3E				ineral		Reiste			21136
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	ne cause on each line.								Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	a. Atheros	clesot	ie C	or on.	17 1	V-, e-1.	. 1	1. 5 200 =	Onset and Death
and the last	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):							
6.	d d ansit	Examiner	Cause. Enter underlying Cause (Disease or injury that initiated events		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
ó	e exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a conse	equence of):							
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	= 0, a	Mec	IF FEMALE:									
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o i	that the de ned by the de detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	r death 5L	Other (spec	ity)	-				
<b>G</b> .	ned b		Part II. Other significant conditions co	entributing to death but not re	esulting in the ur	nderlying cau	se given in Part	t 1.	23e. Did t	obacco us	se contribute to	the cause of death?
Vital Records, P.O.	quires en sign uld be	ed by							1 🗆 '	Yes 2	]No 3□ Pro	bably 4 Unknown
ဝ၁	e law requir has been si le 2 should I	Completed							24a. Was		24b. Were aut	opsy findings available
œ ;	ate ha	mo.							autor perfo 1 □ Yes	rmed2	death?	ompletion of cause of 2 □ No
/ita	sician; The certificate h rector, page	Be	25. Was case referred to medical examiner?				26. Plac	ce of Death	(Check only o		1 1 1 1 1 1 1 1	22110
	rnysi this c al dire	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2				Nursing Ho	me 5 🗆 Resi	dence 6	Sther (Spec	rity) Azzelel Living
u i	aing F h. After i funera	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	.	Injury at Work?		28d. Describe I	how injury	occurred	
Division of	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm str	M eet factory o	1 □Yes 2 □		29f Location /	Ctroat and	A Number of Du	ral Route Number,
2	at or Attendit s after death. Il Director; Ai ed in by the fu	Certification:	4 Homicide determined	building, etc. (Spe	cify)	oct, factory, o	ince		City or To		r Namber of Hui	ar noute Number,
	vithin 24 hours after To the Funeral Directory completely filled in by	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	vsician: To the best of my kiner: On the basis of exami	nowledge, death nation and/or in	occurred at vestigation, ir	the time, date my opinion, de	and place, eath occurr	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
4	withir To th comp	Me	29b. Signature and title of certifier			29c. L	icense number	r		29d. Date	e signed (Month	, Day, Year)
			1 12x 1.1	m_			03280	P2		6/	22/2	009
	ا جا		30. Name and address of person who o	ompleted cause of death (It	em 23a) (Type,	Print)	, ,	0	0			Ml 21136
	· ·		1294.14 Me	1/Y	0-1,10	-7 C	3-8	U. J-	. Ka	173	7.0V	MX 21136
	Stat	e	31. Date Jeh 2#602009	32. Registra s Sign	and and	•						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **a**4 Month Vear **Physician** 2009 06:15 AM /Medical 4a. Facility Name ( not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimoire 12exe Randalls. tow 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)

Montana 5. Social Security Number (In vrs. last birthday) 7. Age **Funeral** 1X M 2□ F Days 517-44-9054 64 **Director** Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h Counts r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Reisterstown Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21136 USA 28 Stocksdale Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2K No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be ပ Martin E. Shoffner Thelma L. Glassey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 Shoffner Wife 28 Stocksdale Ave., Reisterstown, MD Susan 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If ite any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/2/09 Owings Mills, MD Garrison Forest Vet 22. Name and Address of Facility 21. Signature of Fuger 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural
2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

signed by the attending physician and I be detached for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, been si should I this certificate has ral director, page 2: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Baltimore, Maryland 21215-0036

Pages 1 ament of He

3+1

Da. J. Yorke 31. Date filed (Month, Day, Year) State Registrar

4 Homicide

29a. Certifier

Medical

determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

June 24,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Cooks Road

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month June Smith DO: 18M 22 **Physician** 2009 Marshall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Sep. 25, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. **Funeral** Hours 1**X** M 2 □ F 1922 Pennsylvania 181-18-9529 86 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō Examiner must be USA 128 West Ring Factory Road 21014 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify à White 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than Hygiene. Salt Company Salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be is marked of Cora Lee Snyder Edward Paul Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health at Important: If item 27 is any injury or other trau 128 W. Ring Factory Rd., Bel Air, Maryland 21014 Gloria Smith / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 6-24-09 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee lij usa 1317 CokesburyRoad, Abingdon, MD 21009 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Tamponade **Physician** ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner antursym aor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Vear in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy has performed? 2 - No Ýes 1 Tyes certificate 26. Place of Death (Check only one) or Attending Physician; 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 2- No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ၉ 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of filled in by the funeral Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funer

completely fill Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

(check only

29b. Signature and title of certifig

30. Name and address of pers

31. Date filed (Month, Day, Year)

JUN 26 2009

elly

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

June 22, 2009

600 North Wolfe St, Baltimore, MD, 21287

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

barker

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

JUN 2 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number R143201

200 EAST 16TH STREET, FREDERICK, MD 21701

29d. Date signed (Month, Day, Year)

			1 - State of I	Maryland / Depa <i>Cer</i>	irtment of He tificate of D			ene 2009	20564	
	Physici	an	Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death	
	/Medic		HARRY WESLEY STEWART,					23 2009		
	Examir	er	4a. Facility Name (If not institution, give street and number Laurel Regional Hospital		4b. City, Town, or L	ocation of Death		4c. County of Death  Prince George's		
	Funeral	- 4		Age (In yrs. last birthday)			. Date of Birth		thplace (State or Foreign	
Ŀ	Director		190-36-7161 X□M 2□F	62 Yrs.	Months Days	Hours Min. M	(Month, Day, Yoarch 5,	1947 Pen	nsylvania	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits	
	Maryli f sho ied at	ō	MD Howard	Laurel					1 □ Yes 2√No	
	n the r 28a	Director	10e. Street and Number	Daurer	10f. Zip Code		10g	. Citizen of What Co	ountry?	
	th wit		9320 Kenbrooke Court		2	0723		USA		
	er dea	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13. V s?	Vas Decedent of Hisp f Yes, specify Cuban	panic Origin? (Specif , Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit		
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adloal Examiner must be notified at	by F	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 [ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date:	□No 1966- s: 1968	☐ Yes 2 No	Specify:		Specify:	White	
5-0036	72 hou 'natura dical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupat	ion	16	b. Kind of Business		
Ž	be filed within 72 ho ntal Hygiene. d other than "natul event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4d	or 5+)		ring most of working				
Z   D	filed w Hygier other th	Co	12th 2  17. Father's Name (First, Middle, Last)	Acc	countant	8. Mother's Name (F		Dept. of 1	Defense	
ä		To Be	Arthur I. Stewart		1	Helen		ambach		
ar Z	2 should be and Mental is marked raumatic ev	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street an	nd Number or Rural F			Zip Code)	
, Mai	ロモレキ		Jeannie M. Stewart/Wif			ke Court,	Laure1	l, MD 20	723	
saitimore,	ges 1 t of H If iter or oth		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Removal from Sta	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Date	e 20	c. Location - City or	Town, State	
	it. Pa rtmen rtant; njury		4 ☐ Donation 5 ☐ Other (Specify)	MD Veter		ery 6/29/		Crownsvill		
r T	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee			of Facility Dona t Avenue,			ome, P.A. 707	
	to.		23a. Part Enter the disease, or complications that caus shock, or heart failure. List only one cause on each						Approximate Interval Between	
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	/Medical Examiner		resulting in death)	as a consequence of):						
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to timeculate cause. Einter Underlying Cause (Disease or injury that initiated events							
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. DOX	The law requires that the death the has been signed by the atten sage 2 should be detached for u	hysician/M	in the past 12 months?  1 Ves 2 No 4 Pregnant	2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year	
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ב ב	he lay e has age 2	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
	ding Physician: The n. After this certificate he funeral director, page	Be Co	25. Was case referred to medical		2	26. Place of Death (C	1□ Yes 2X Check only one)	No 1 ☐Yes	XXNo	
5	hysic his ce Il direc	10 0	examiner? 1 ☐ Yes 2 💢 No Hospital: 1 📉 Inpa		Other			ce 6 □Other (Spe	cify)	
	Ilng P	io io	- Little Control of the Control of t	njury 28b. Time of Injury	28c. Injury a Work?		d. Describe how	injury occurred		
131011	Attend death death sctor: y the	ficat	2 Accident investigation  3 Suicide 6 Could not be determined determined	njury - At home, farm, stre		es 2 No	. Location /Stree	et and Number or Ri	ural Route Number	
Ś	s after al Dire	Certification:	4 ☐ Homicide determined building,	etc. (Specify)			City or Town, S	State)	,	
4	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	Medical (	29a. Certifler (Check only one)  1 Certifying Physician: To the besigned and manner and manner.	of examination and/or inv	occurred at the time restigation, in my opin	e, date and place, and nion, death occurred	d due to the caus at the time, date	se(s) and manner as	s stated. e to the cause(s)	
,	To the within !	Mec	29b. Signature and title of certifier	nateu.	29c. License r	number	29d.	. Date signed (Mont	th, Day, Year)	
			1 (1 mum		055	1861		June 23	3, 2009	
			30. Name and address of person who completed cause of		Print)					
	Sta	to.	Abdul Munim, MD 83		ane, Lau:	rel, MD 2	20707			
	Registr		31. Date filed (Mon), IN 2.6 2009	strar's Signature						

DHMH 17 Rev 1/2001

Robert Earl Smit	h, J	Please Type Stat	or Print in B e of Maryland						ible.	09 2056
		1- For State Registrar		Certif	icate c	of Death			, No.	
Physicia Medical Examir		1. Decedent's Name (First, Middle,L Robert Ea		Smith,	Ir			2. Date of Death Month June 22, 20	Day Year	3. Time of Death 0249 hrs
		4a. Facility Name (if not institution,			<u> </u>	4b. City, Town, o	r Location of Deat		4c. County of Dea	th
		Harbor Hospital Center				Baltimore				
Funeral Director				je (In yrs. last	-	If Under 1 Ye		n.	(MM/DD/YYYY 9. B	ign
	ŀ	Usual Residence of Decedent	X M 2 F	22	Y	rs.	1_1_	Берt. 1	0, 1986 <sub>1</sub> °	ountry) MD
w any	Ì	10a. State 10b. County		10c. City, To	wn or Loc	ation				10d. Inside City Limits
Maryland 28a-f show a d at vince.	اق	Maryland Maryland		Balt:	imore					1 X Yes 2 No
e Mary	Director	10e. Street and Number 3815 10th Street				10f. Zip Code	225		g. Citizen of What Co USA	untry?
with th		11. Marital Status	12. Was Deceden	Ever in U.S.	13. W			Specify Yes or No-		erican Indian, Black,
death or iten	Funeral	1 XNever Married 2 Marri	1 Yes 2	? 	If	Yes, specify Cuba	in, Mexican, Puerl	o Rican, etc.)	White, etc.	
iral",	호	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:	majotod) 16		Yes 2 X N		Lucrk dana	Specify: What 16b. Kind of Business	nite
72 hou "nati	le e	Elementary/Secondary (0-12)	College (1-4 or	, ,		most of working life			TOD. TAITE OF DESITIOS.	, maddiy
0036 vithin ene.	Completed	12			G1a	ızer		_	Construct	ion
215-0036 be filed within 7 had Hygiene. -ked other than ent, the Medica	Be Co	17. Father's Name (First, Middle, La Robert Ear	<i>'</i>	+h			18.Mother's Nan Mary	ne (First, Middle, M Lee	aiden Surname) Dunkes	,
212 ould be Menta mark		19a. Informant's Name/Relationship			19b. Maili	ng Address (Stre			per, City or Town, Sta	
MD d 2 sho Ith and n 27 is		Mary L. Smith (	Mother)						PA 17356	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation	Removal from S	1		osition (Name of co other place)		Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	Н	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		Loud		rk Cemet		26/09	Baltimore,	Maryland
Bal permi Depa Impo injur		21. Signature of Funeral Service Lic	ense						k Funeral ore, MD 21	
Physician		23a. Port i. Enter the disease, or confailure. List only one cause on	nplications that caused	the death. Do	o not enter	the mode of dying	, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer			a. Narcotic		cati	on (hero:	ín)			Death
		Sequentially list conditions,	Due to (or as a cons	equence of):						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):						
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	Aedi	IF FEMALE:	23c. If yes, outco			,, ,	,		23d. Date of delive	erv
Box 68760, c death certificate be to the attending physicized for use as the buriand for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 🔲 !	etal death 3	Ectopic preg	nancy	Month	Day Year
30x death c	ysic	1 Yes 2 No 9 Unkno		t time of death	5(	Other (Specify)	<del></del>			
s, P.O. B ires that the de is signed by the	by Ph	Part II. Other significant condition	s contributing to dea	th but not resu	ilting in the	underlying cause	given in Part I.			to the cause of death?
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cords, law requir has been s	Completed							24a. Was a autop: perfor	sy prior to	autopsy findings available o completion of cause of ?
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n of V ding Phy.	입	27. Manner of Death	28a. Date of Inj (Month, Day,	ury 28 Year)	8b. Time o		ury at Work?		ow injury occurred	
ivision or Attendi after death. Director:	atio	Natural 5 Pending Accident Investig	ation Fu 0/22	·	d 02		Yes 2X No	unk		
Division of Vital Records, P.O. ontail or Attending Physician: The law requires that the ours after death.  The law record After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 X Could n	ot be	resid	e, farm, sti lence	reet, factory, office	building, etc.	or Town, S	tate 3815 10t Ore, MD	Rural Route Number, City h St
E 8 F E	ا ا	29a. Certifier 1 Certifying Phys	ician: To the best of n	ny knowledge,	death occ	curred at the time,	date and place, as	nd due to the caus	e(s) and manner as st	tated.
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examin	ner:On the basis of exa and manner stated	mination and/	or investig			at the time, date a		
	Σ	29b Signature and title of certifier	10/1		,	1	se number		29d. Date signed (A June 22, 2009	Month, Day, Year)
	k	30. Name and address of person wh	o completed cause of	death (Item 23	Ba)	0.0			Julio 22, 2009	
			sistant Medical E			enn Street, Ba	ltimore, MD 2	:1201		
Sta		31. Date filed (Month; Day, Vear)	32. Registra	ar's Signature	back					
Registi	वा	<u> </u>	Conera	19.19	THE STATE OF				OCME	···

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:49A.M 24, 2009 June Charles Joseph Simmons 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City John Hopkins Bayview Med.Ctr. Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) 1**X** M 2□ F Mar6,1941 68 214-40-1692 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Baltimore Dundalk Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21222 2730 Southbrook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Greif Bros. Fork Lift Driver Corp. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Simmons Emma Grace Manor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2730 Southbrook Road Dundalk, Md. 21222 Lana L. Simmons / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6-27-2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Toler 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Due to lo Due to ler as a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🗓 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760. Records,

burial-trar attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Hospital or Attending Physician: the 24 hours after deat Funeral Director: filled in by within 24 hor To the Fune completely fi

**Physician** 

**Examiner** 

**Funeral** 

Director

Show

Director

Funeral

₹

Completed

Be

Examine

Physician/Medical

ğ

Be Completed

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check on one)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffied at once.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

/Medical

State Registrar

31. Date filed (Month, Day, Year) JUN 2 6 2009

29b. Signature and title of certifier

6 ☐ Could not be

30. Name and address of person who completed cause of death (nem 23a) (Type, Print) \$110 Philadelphia Road, Stel06, Baltimore, Md21237 Sheila Alongi, M.D.

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 46595

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:15 A M 2009 June 24 Shirley D. Tolleson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 👽 F July 23,1933 420-40-9797 <u>Florida</u> Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination to a wiffed at 1 ☐ Yes 2 ▼ No Director Owings Mills Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9204 Groffs Mill Drive 21117 Funeral death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 ∏ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify. Specify. ģ 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Accounting Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Essie Rucks ၉ Doyle Dover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12801 Sagamore Forest Lane, Reisterstown, MD 21136 Daughter Amy T. Johnson permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 6/25/09 5 Other (Specify) 4 ☐ Donation Hampstead, MD Carroll Cremation uneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 J. Wayne Osterling Reisterstown, MD Eline Funeral Home 23a. Sart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear gailure. List only one cause on each line. Immediate Cause (Final minures **Physician** Robothle disease or condition resulting in death) /Medical ue to (or as a consequent of): Examiner MCreanc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) 9 | Unknown 9 Unknow s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 perform Physician: The certificate 1 ☐ Yes 2 ☐ No 2 NO 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one)

State Registrar

29b. Signature and title of certifier

within 2

Maryland 21215-0036

altimore.

P.0.

Division of Vital Records,

0

N. Churles ST

29d. Date signed (Month, Day, Year)

and manner stated.

W 32. Registrar's §

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 0250 AM **Physician** 25 2009 George N. Taylor JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. N/A AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/25/1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days **1**√2 M 2 □ F Maryland Director 218-58-8350 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, I'm Medical Evolution and the nutth of an unit be nutthed at 10c. City, Town or Location 10a, State 1 ☐ Yes 2 No **Funeral Director** MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21229 United States 4101 West Drive 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 🏖 No Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manufacturing Forklift Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hall Bradds Raymond N. Taylor ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is I any injury or other traul Once. Donna L. Knell (Spouse) 4101 West Drive, Baltimore, Maryland 21229 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/29/2009 Baltimore, Maryland Bayview Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 eco Pary. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only/one cause on each line. Approximate Interval Between and Death Immediate Cause (Final INFARCTION MYOCARDIAL **Physician** durs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COLONARY ARTERY DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner attending physician and for use as the burial-trar P.O. Box 68760x Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the a 9 Hinknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) \( 5 \) \( \text{Residence} \) \( 6 \) \( \text{Other (Specify)} \) 1 Yes Ż No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Mannet of Death 28c. Injury at Work? Natural or Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afti completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JUNE 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 AVENUE BALTIMORE CATON 21229 NOKUR 1 900 S. SAMUEL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 26 2009 Registrar

DHMH 17 Rev 1/2001

MORMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Registrar Ce.	rtificate of Death		eg. No. 2009 2056	9	
r	Physicia	an	1. Decedent's Name (First, Middle, Last) Linda D. Thomas		2. Date of Dea Month	Day Year		
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June	20, 2009 11:31A <sup>M</sup>	_	
	Examin	er	3324 Foster Avenue	Baltimore City				
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F F 7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	(, Year) Country)	n	
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo.	ocation		10d. Inside City Limits	3	
	Maryl -f sho	tor	MD Baltimon	ce City		1 X Yes 2 □ No	,	
	or 28a	Direc	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?		
	ath wi	eral I	3324 Foster Avenue	21224		USA 14. Race - American Indian,		
_	fter de ritem ineri	<b>Funeral Director</b>	1 Never Married 2 Married 1 ☐ Yes 2 TNo	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.		
3-003e	ral",o	ρ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White	_	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Adral Exerciting mat be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng	16b. Kind of Business/Industry		
7 7	l withir jiene. r <b>th</b> an	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	Bartender		Bar Business		
פ	be filed ntal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle,	Maiden Surname)		
yland	should b and Ment s marked umatic e	2	Clyde Robertson	Pauline				
Mar	d 2 sh th and 7 is m traum			ng Address (Street and Number or Run				
_	s 1 and f Health item 27 other to		Cammie Brooks - Daughter 332  20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	e, Bal	timore, MD 21224 20c. Location - City or Town, State		
<u>E</u>	Page: nent o ant: If ury or			vn Cemetery 6-2	4-09	Baltimore, MD		
paltimor	permit. Pages 1 a Department of He Important: If item any Injury or othv		1 / 5 / 1/1			Ashton Funeral Hom	ne	
_	© □ = # Ø		23a Part 1 Enter the disease or complications that caused the death. Do not en	PA, 2134 Willow	Sprin	g Road 21222 rest, Approximate Interval Between		
	Dhuaisian	) ()	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	CANCER	•	Interval Between Onset and Death	C	
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	CANCEL		3 15/41	_د	
	Examiner	L	Sequentially list conditions.					
	ited nsit	nine	Sequentially list conditions, if cry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
<b>5</b>	tificate be executed ig physician and as the burial-transit	edical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
68/60,	ate be hysicii the bu	lical	d				_	
Ž	certific Iding p		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	- 1	
ž PO T	death e atter id for u	iciar	1 Type 2 Months? 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year		
7. O	at the d by th stache	Physician/N	9 ☐ Unknown	underduite accuse alives in Boat I	23a Did to	bbacco use contribute to the cause of death?	_	
ďS,	ires th signed	Ş	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Fatt i.		res 2 No 3 Probably 4 Unknow	vn	
Hecords,	w requ	etec			24a. Was	an 24b. Were autopsy findings availab	le	
T T	The lar	Completed			autop perfo 1 □Yes	psy prior to completion of cause of death? 2 No 1 □ Yes 2 □ No		
VItal	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?	26. Place of Deat				
0	Physic this or	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			dence 6 Other (Specify)	_	
0	ding th. After funer	tion	27. Manner of Death  1  Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day, Year) Injury	Work?  M 1 □Yes 2 □No	Zuu. Describe i	low injury occurred		
DIVISION	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (: City or Tox	Street and Number or Rural Route Number, wn, State)		
	e Hospita 124 hours e Funeral	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal one of the best of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)		
	To th Within To th	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)		
			button (MI)	D43934		JUNE 23, 2009		
	V		30. Name and address of person who completed cause of death (Item 23a) (Type DWIGHT IM, MD 22.7	ST PAUL PL	ACE	BALTO MD 2100	2	
	Sta		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	47	•			
	Registr		JUN 2 6 2009 Brown B.	and .				
DHI	MH 17 Rev 1/2	:001						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 9892 6/26/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last Day **Physician** 2004 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. Gity, Town, or Location of Death Examiner 8. Date of Birth Month, Day, 5-24-If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Director 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Adol Event in crust by natified an once. 1 Yes 2 No Director 10g. Citizen of What Country? and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) echnicia Qu 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11106 Informant's Name/Relationship (Type. Print) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CUI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) cate has been signed by the page 2 should be detached in 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\text{\backslash}\) No 2 □ No 1 □ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier phy sica 7200H 21,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teresa K. Muns, MD 5601 Loch Raven Blvd. Baltimore, MD 21239 3a. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 6 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Perspand of Mary and Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Valenziano 2. Date of Death Pasquale 7onth **Physician** :40 AM nziano 200 /Medical 4a. Facility Name (If not inditution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 21, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Year) Days 1 X M 2 □ F 1919 Italy 217-40-7311 90 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examilise must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21043 8934 Chapel Avenue by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2X No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, if a Made once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Butcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giuseppe Valenziano Maria Di Marco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8938 Chapel Avenue; Ellicott City, MD 21043 Pina Culotta Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial 6/23/2009 Timonium, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign ture of Funeral Service Lice, see 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that be used the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** nterstitia lears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Mospital or Attending Physician: The law requires that the death certificate be executed Exam cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/D110 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ within 24 hours after death.

To the Funeral Director After th completely filled n by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred **L** Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

21044

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

For State Registrar		C	ertifica	ate of Dea	th	Re	g. No. 🥤	nno	9 2057
Decedent's Name (First, Middle, La	ist)					2. Date of Death Month	Day	Year	3. Time of Death
Anthony Michael	Votta					June 23	, <sup>Day</sup> 200	)9	10:35 P M
. Facility Name (If not institution, giv				ity, Town, or Local	ion of Death			unty of Deat	
Atlantic Genera	-			erlin	30415-	T	WOI	cceste	
Social Security Number 6. S	Sex 7. Ago 124 M 2 ☐ F	e (In yrs. last birthda Q7 Yrs.	Month		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Sept 13,	Year)	Co	thplace (State or Foreign ountry)
218-18-5264		87 Yrs.				Sept 13,	192	ı Mal	ryland
a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
aryland Worcest	er	Berl	lin						1 ☐ Yes 2 🔀 No
. Street and Number		DCL		Zip Code		10	g. Citizen	of What Co	ountry?
39 Mystic Harbou	ır Blvd.			21811			USA	A	
Marital Status	12. Was Decedent I	Ever in U.S. 1	3. Was De	cedent of Hispani	c Origin? (S	pecify Yes or No-	14.	Race - Ame	erican Indian,
1 ☐ Never Married 2 🔀 Married	Armed Forces?			pecify Cuban, Me		rican, etc.)		Black, White	e, etc. White
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	s 2 X No Spe	ecify:		Sp	ecify:	MIITE
15. Decedent's E (Specify only highest gra		i (G	ive kind of	Jsual Occupation work done during	most of worl		6b. Kind	of Business	/Industry
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. Father's Name (First, Middle, Last	)					ne (First, Middle, M		name)	
Michael Votta						ine Scha			
a. Informant's Name/Relationship						ral Route Number,			Zip Code) and 21811
Theresa C. Vott	a wile				ur brv				Town, State
a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		crematory (	or other place)				-	
4 ☐ Donation 5 ☐ Other (Speci		Crest La	awn M	em Garde				intter	7-1110 MD
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Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical Medical Certification: To

> 3 🗋 Suicide 4 Homicide

29a. Certifier

Director

Completed by Funeral

Be

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

D0054307

June 23, 2009

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

J. Van Egwowd MD, 9733 Healthway Drive, Berlin, MD 21811

31. Date filed (Month Day, Year)

32 flegistrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 3. Time of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day June 22, 2009 0605 hrs Joyce Anita Williams Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Season's Hospice 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 5. Social Security Number 06 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Country) Months Days Director M Yrs 1973Maryland 212-<del>96</del>-3767 36 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Auv Yes 2 23a or 28a-f show notified at once. Maryland N/A Baltimore death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 205 Cherry Hill Road 21225 USA 14. Race - American Indian, Black, Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married Married 2 X No Yes Specify: Black Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.

ant: If tem 27 is marked other than "natural" on If Yes, Give Yeer Yes 2 X No specify: 3 Widowed 4 Divorced 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Charles Hicky College (1-4 or 5+) Elementary/Secondary (0-12) tranmatic event, the Medical timore, MD 21215-0036 Youth Counselor School vear 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joan Whiting Dennis J. Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 205 Cherry Hill Road Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print ) Husband Charlie Frank Williams 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition /26/09 Greenmount Cemeter Baltimore, Maryland Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses <u>5240 Reisterstown Rd</u> Baltimore,Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a Pneumonia & sersis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) b Probably effects of drug use Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last rand transi The law requires that the death certificate be executed hysician/Medical **#5, per FH g893 7/8/09 TT** 23a, PII,27,28a-f,perME, X AMENDED X UNPENDED attending physician or use as the burial g895 9/23/09 Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Yea Day Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. ā Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Yes 2 ✓ No 3 Probably 4 Unknown Anoxic brain injury; ventilator dependence Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autonsy has death? performed? page 2 1 🗸 Yes ✓ Yes 2 2 No certificate 26.Place of Death (Check only one Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Yes 2 X No unk death Pending Director the 6/28/09 unk 2 Accident Investigation 28f. Location (Street, and Number or Rural Route Number, City or Town, State) 205 Cherry Hill Rd Brooklyn PArk, MD filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide Season's Hospice within 24 hours a To the Funeral I completely filled determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Tot and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe OK 29b. Signature and title of certifier June 23, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) OCME Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 32. Registrar's signaturalle

DHMH 17 Rev 1/2001

Registrar

Termaine	W	ILLIE WOMACK		
9-04921		Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygiene	e Legible -	
JNK UNK		- For State Certificate of Death	Reg. No.	2009 205
Physician	_	Decedent's Name (First, Middle,Last) Month	of Death h Day	3. Time of Death Year 0208 hrs
ledical Examin		JETHAINE VIIIE	22, 2009 4c	. County of Death
	П	Johns Hopkins Hospital Baltimore		
Funeral	7	5. Social Security Number 7, 6. Sex		DD/YYYY) 9. Birthplace (State or Foreign
Director		1 XM 2 Yrs. Months Days Hours Min. 9	18-19	76 Country) M.D
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
* .		MD BAHIMOLE		1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code	10g. Citi	izen of What Country?
h the N 3a or		710 EAS+ 71   21218	e or No-	14, Race - American Indian, Black,
or items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, 6	etc.)	White, etc.
Rer de:		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify:		Specify: BIACH
nours a	od be	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work dor during most of working life. DO NOT use retired)	ne 16b.	Kind of Business/Industry
36 in 72 h	plet	Elementary/Secondary (0-12) College (1-4 or 5+)  UN EMPIÓYE d	10	NEMPLOYED
5-0036 iled within 7 Hygiene. I other than the Medica	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Inc.)		n Surname)
1215 l be fill ental H arked	B	19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Ro	oute Number (	City or Town State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once	٢	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Ro  19c EAS + 91 5 + BA1:		9 2/2/8
e, MD and 2 sho Health and item 27 is	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date		. Location - City or Town, State
nor Pages   ent of   nt: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  Amage: Crematic of the place of the pl	09 13	Alto MIS
Baltimore, permit. Pages I an Department of Hee Important: If itel		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ph., 11	PA.U	EATHERFORDFSP
	_	23a. Part I. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir	+ 134	17/11/10 6/6/3
Physician M dical		failure. List only one cause on each line.		Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Stab wound of criest  Due to (or as a consequence of):		
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	min	cause. Enter Underlying Cause (Disease or injury that initiated    Disease or injury that initiated		
Tansit uted	Ë	events resulting in death) Last  d.  d.		
e exec	dica	UNPENDED X AMENDED Item#6perFH,G892,6/26/09,WS	- 17	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	2	23d. Date of delivery  Month Day Year
x 68 h certi	iciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		
Bo he deal	hys	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
P.O. es that the signed by be detach	þ	Tattii. Other significant container Contributing to East 2011	1 Yes 2	No 3 Probably 4 Unknow
rds, require been si	eted		24a. Was an autopsy	24b. Were autopsy findings availa prior to completion of cause of
eco he law ite has age 2 sl	Completed	1	yes 2 ves 2	
al R ian: T certifica ctor, pa	Be C	25. Was case referred to medical examiner? 25. Place of Death (Check only of the control of the		sidence 6 Other:
F Vit Physic or this c	10E	1 V Yes 2 No 200 Date of Injury 28h Time of Injury 28c Injury at Work? 28d	Describe how	injury occurred
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director.	ion:	1 Natural 5 Pending Jun 21, 2009 2311 hrs 1 Yes 2 ✔ No	ject stabbe	
/isic	ficat	Could not be 200.1 (add of injury	or Town State	et and Number or Rural Route Number, (
Division of Vital I 24 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification:	4 V Homicide determined (Specify) Townhouse / Rowhouse		Avenue, Baltimore, Md.
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the	to the cause(s) time, date and	place, and due to the cause(s)
To the within To the comple	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		9d. Date signed (Month, Day, Year)
		California O.C.M.E.		une 22, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Zahiullah Ali M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
		20 Posistratio Signature		
S Regis	tate tra			

ORIGINAL

09-04827 Clyde Wallace Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

	1- For State Certificate of Death Certificate of Death	Reg. No.	109 205/5
Physician/	1. Decedent's Name (First, Middle,Last)	Date of Death     Month Day Year	3. Time of Death
Medical Examiner	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	June 18, 2009	1114 hrs
	Harbor Hospital Baltimore		
Funeral Director	5. Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  1 M 2 F 0 2 Yrs. Months Days Hours Min  Usual Residence of Decedent		9. Birthplace (State or Foreign Country)
d Sc. aoy	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No
a or 28a-f sh tiffied at once	10e. Street and Number 10f. Zip Code	10g. Citizen of Wh	at Country?
3 office N	159 Barbara Road. 21146	us,	9
r death with or items 23 cmust be og	11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  13. Was Decedent of Hispanic Origin? (Sometime of the specific Cuban, Mexican, Puerton of the specific Cuban, Pu		- American Indian, Black, , etc.
s after ral", niner	3 Widowed 4 Divorced If Yes, Give Year V/EFN/M 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	Specify:	White
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Base: If item 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be sotiffed at once.  To Be Completed by Funeral Director	Elementary/Secondary (0-12)  College (1-4 or 5+)  during most of working life, DO NOT use reti		on Franchise
215-0036 be filed within 7 ntal Hygiene. rked other thas cot, the Medica Be Comple	17. Father's Name (First, Middle, Last)  Cabinet MakeR  18. Mother's Name	(First, Middle, Maiden Surname)	1 PURY/IURE
21215-Could be filed volume to the filed volume to the filed volume to the file evect, the file evect, the To Be Co	19a, Info ant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	ural Route Number, City or Town	n, State, Zip Code)
re, MD : 1 and 2 sho Health and fitem 27 is	Cady Wallace - Wife 159 Barbara Ra 20a. Method of Disposition (Name of cemetery,	Date 20c. Location -	City or Town, State
MOF Pages ient of iet: If	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	-24-09 Balk	MODE MA
Baltimore permit. Pages 1 a Department of H Importact: If it iojury or other	21. Signature of Funeral Service Licensee  22. Name and Address of Ficility By  Home, PA, 2 (34 / 1)	radley-Askto	N FUNERAL PLA d 21222
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Hypertensive atherosclerotic card	or respiratory arrest, shock, or head liovascular dise	Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. complicated by gastrointestinal bleed Due to (or as a consequence of):		Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  b		
vecuted  t and  -transit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
2.   a a e	XUNPENDED AMENDED 23a,27,perME, g892 6/29/09 TT	<u> </u>	
0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 5 Other (Specify)	23d. Date of Month	delivery Day Year
Box he death y the atte	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contri	oute to the cause of death?
P.C es that igned   be deta	Contributing to death part not resulting in the directlying cause given in rate in		Probably 4 V Unknown
i of Vital Records, P.O. Box 68' ing Physician: The law requires that the death certificate this certificate has been signed by the attending tuneral director, page 2 should be detached for use as on: To Be Completed by Physician.		eutopsy p performed? d	Vere autopsy findings available rior to completion of cause of eath?
II Re rifficat or, pag	25. Was case referred to medical 26.Place of Death (Check		Yes 2 No
f Vital Physician or this cert ral directo To Be		ng Home 5 Residence 6	Other:
	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurre	ed
Division o spital or Attrodieg orous after death. orous after death. filled in by the func	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	er or Rural Route Number, City
Division of Vital Division of Vital Division: To the Hospital or Atteoding Physician: within 24 hours after death. To the Fuocral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the cone of th		
Ne se	29b. Signature and title of certifier 29c. License number	29d. Date signe	ed (Month, Day, Year)
	Carde Heller O.C.M.E.	June 19, 20	009
15 V	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	11	
State Registrar	31. Date filed (Month, Day, Year)  JUN 2 6 2009  32. Registrar's Signature		

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** James R. Wood 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMOREMO HOSPITA 161025 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 **M** 2 □ F 1/21/28 219-22-9951 Maryland Director 81 Usual Residence of Decedent within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Midical Experient a ust be notified at 1 XYes 2 □ No Director MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4417 Eldone Road 21229 USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced WW II White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any Injury or other traumatic event, I'm Midde. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Truck Driver</u> Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Wood Ruth Willis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna F. Wood / Wife 4417 Eldone Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest V. A.: 7/2/09 Owings Mills, MD 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Liqui 3620 Wilkens Ave. Baltimore, Maryland 21229 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part1. Enter the disease, or conshock, or Heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive ZycaRs /Medical (or a consequence of): Examiner monary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the detached t P.0. 9 Unknown signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Viseuse Vital 1 ☐ Yes 2 No 2 No Physiclan: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation death. 1 □Yes 2 □No the f 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

State

29b. Signature and title

30. Navne and address of pe

31. Date filed (Month, Day,

TIMOR

11.

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

4419 23rd Parkway

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Crematory

18. Mother's Name (First, Middle, Maiden Surname)

Temple Hills, Md.

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year) 0

06

Clinton, Maryland

20019

Year

Louise Ruffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

T2

12, 2009

Date June

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinant, ust be nothed at within 72 hours after Baltimore, Maryland 21215-0036 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once.

**Physician** 

/Medical

Examiner

10a. State

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Billy

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

Leonadra P. Anderson/ Daughter

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

Anderson

Director

Funeral

ģ

Completed

Be ပ

**Funeral** 

Director

show

**Physician** /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-transit signed by the a d be detached for has been certificate or Attending Physician: this funeral After t within 24 hours after deam.

To the Funeral Director: Af

Physician/Medical

Completed by

Be

Certification: To

Medical

29b. Signature and title of certifie

Division of Vital Records, P.O. Box 68760,

22 Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Libenses 4001 Benning Rd. NE Washington, DC Approximate Interval Between Onset and Death 23a. Part 1 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock wheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital

State Registrar Varsha Vauikar, MD7503 Surratts Road 32. Registrar's Signature JUN 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

DHMH 17 Rev 1/2001

29c. License number

Clinton, Md.

D0064289

### 09-04449

Oluwawemimo A Akinuli

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2009 20578

_		Registrar		Ce	runcate d	ט ונ	caur					Reg. No.		
Physicia edical Exami	an/	1. Decedent's Name (First, Mide	wemimo A.	Akinuli	L						Date of De Month June 4, 2	Day 1009	Year	3. Time of Death 0555 hrs
		4a. Facility Name (if not instituti Indian Head Highway	-				City, Tow		ocation of	Death			unty of Deatl ce George	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		N	Under 1	Year Days	If Under	Min.		,		thplace (State or Nigeria
Director		213-17-4017 Usual Residence of Decedent	1 M 2XF	36	6 Y	rs.					12-12	2-1972		ouritry)-
v any		10a. State 10b. County	,	10c. City	, Town or Loc	ation								10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	to	DC		Wa	shingt		of, Zip Co	do				10a Citizen	of What Cou	
th the Mary 23a or 28a notified at	Director	10e. Street and Number 3006 Adams St	N E				200				1	U.S.		,.
with the ms 23a be noti		11. Marital Status	12. Was De	cedent Ever in L	1.S. 13. V	Vas De	ecedent	of Hisp	anic Origin	n? (Speci	ify Yes or N			ican Indian, Black,
e, MD 21215-0036 He and 2 should be lifed within 72 hours after death with the Maryland He and Phiele when the maryland item 27 is marked other than "natural", or items 23a or 28a-f short rammatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 1 3 Widowed 4 D	Married 1 Yes ivorced If Yes, Give Yes	1 Yes 2 X No								ecify: B1	ı cîz	
2 hours afte "natural", Examiner	d by	15. Decedent's Education (Sp	Lor Dates:		16a. Deced	lent's L	Isual Oc	cupatio					of Business	
36 in 72 ho han "us lical Es	Completed	Elementary/Secondary (0-12		1-4 or 5+)				-			)	T o.1	ru. Co	Tno
15-0036 filed within 72 Hygiene. d other than ", the Medical I	Som	17. Father's Name (First, Middl	5 e, Last)		Compu	ter	Spe				irst, Middle	, Maiden Su	rname)	inc.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Bobson Akin									injis			
MD 2. d 2 should lith and M n 27 is ma	2	19a. Informant's Name/Relation  Bobson Akinu	/m . 1	er)	900								or Town, Stat	
nore, MD ages 1 and 2 short of Health and nt: If item 27 is		20a. Method of Disposition  1 X Burial 2 Crematic		20b.	Place of Disp crematory or	osition	n (Name				Date	20c. Loc		r Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other	Specify:		te of	Hea	aven					)9 Ma1	yland	
Baltimore permit. Pages 1 Department of F Important: If injury or other	/	21. Sign ture of uner hervio	e Licensee	125	* /								eral H	ome, Inc.
Physician		2 art I. Enter the disease, of failure. List only one cause	or complications that	caused the deat	h. Do not ente	r the n	node of o	lying, s	uch as car	rdiac or re	espiratory a	rrest, shock	or heart	Approximate Interval Between Onset and
/Medical caminer	1	I mediate Cause (Final dise is or condition resulting in death)	se a Multiple In											Death
		Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that limitated	e n	a consequence								G 134		
ecuted and transit		events resulting in death) Last		a consequence	of):									
7 <b>60,</b> cate be exe physician a	an/Medical	UNPENDED	AMENDED											
18760, tifficate be ing physici as the buri	JW/W	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		, outcome of pre birth		Fetal (	death	3	Ectopic	pregnanc	у		Date of delive onth	Day Year
O. Box 6 at the death cer 1 by the attendi	Physicia	1 Yes 2 No 9 V U		nant at time of d	leath 5	Other	(Specify	) _						(1)
O. Enat the decided	by Ph	Part II. Other significant cond			resulting in th	ne und	erlying ca	ause gi	ven in Par	t I.				o the cause of death?
ls, P.C quires that on signed			<u> </u>						<u> </u>		1 Y			obably 4 V Unknown autopsy findings available
of Vital Records, ng Physician: The law requir offer this certificate has been someral director, page 2 should I	Completed	·				_				_	aut per	opsy formed?	prior to death?	completion of cause of
tal Recional The certificate		25. Was case referred to medic	cal	<del></del>			26	Place	of Death (	Check on	1 Yes	8 2 No	1 🗸	Yes 2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpati						Home 5		e 6 🗸 Oth	er: Scene
_ = . ` ∈			nding Jun 4,	e of Injury th Day Year) 2009	28b. Time 0100 hrs	,	` I		y at Work? es 2 ✔	Isi	8d. Describ ubject pe	e how injury edestrian	struck by	vehicle
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Co	ould not be	ace of Injury - At	home, farm, s	treet, f	actory, c	ffice bu	uilding, etc		or Town	State)		Rural Route Number, City
Dj Hospital 4 hours a Funeral J		29a. Certifier	Physician: To the be	Highway est of my knowle	edge, death oc	curred	I at the tii	me, da	te and plac					n Road, Accokeek, MD ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Ex	caminer:On the basis and manner	of examination			, in my o	pinion,	death occ			te and place	e, and due to	the cause(s)
	Σ	29b. Signature and title of certi	fier		λ			icense D.C.N	number 1.E.	OGN	ΊE		te signed (A 5, 2009	fonth, Day,Year)
		30. Name and address of person	on who completed a	The su	em 23a)									
e 1		Theodore M. King, J	r., MD. Assis	tant Medical	Examiner	1	11 Pen	n Str	eet, Bal	timore,	MD 212	01		
S Regis	tate trar	11131 1 8 7111	9 Senera	Registrar Signa	Jak									

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

After this certificate eral Director: After th filled in by the funeral death. To the Hospital within 24 hours a To the Funeral L completely

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

**JUN 12** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring, Md 20910 Kshama Garq M.D. 31. Date filed (Month, Day, Year)

and manner stated

Registrar's Signatur

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D60826

29d. Date signed (Month, Day, Year)

June 7,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State RegistraMFND#20bperFH6/23/09, BMW, MCCo Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:15 p <sup>M</sup> June 4, 2009 Nathan Isaac Belansky 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) North Potomac Montgomery 12509 Shoemaker Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/13/1927 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Hours Min. 1 3 M 2 □ F Michigan 81 089-20-2075 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Montgomery North Potomac 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20878 12509 Shoemaker Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc 1 ☐ Never Married 2 X Married 1 TYes 2 XNo white If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney/Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dina Parkett Jacob Belansky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12509 Shoemaker Way, North Potomac, Maryland 20878 Frances Mary Belansky-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date June 7, 2009 <del>05/07/20</del>09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olney, Maryland Judean Meml Gardens 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc. 21. Signature of Joneral Service Licensee M 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years a Hairy Cell Leukemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after coppartment of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exementane.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

Exami and the burial-tran physician attending p signed by the certificate has been s rector, page 2 should director, Be Certification: To this After n 24 hours after death.

e Funeral Director: At

<u>م</u>

Medical

1 Natural

3 Suicide

29a, Certifier

2 Accident

4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 HInknown Coronary Artery Disease Completed

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

5 Pending investigation 6 ☐ Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

24a. Was an autopsy performed

26. Place of Death (Check only one)

1 □Yes 2 1 No

29c. License number D26449

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

June 8, 2009

address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Barry S. Talesnick, 5454 Wisconsin Avenue, Suite 925, Chevy Chase, MD 20815

State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUN 12 2009

and manner stated.

To the Hosp within 24 ho To the Fune completely f

10

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 15 3:55 AM Virginia Josephine Barnhart June 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Homewood Retirement Center Williamsport Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1 □ M 2XX Months Days Hours Oct.9, 219-16-2771 86 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 TXNo Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9830 Downsville Pike 21740 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Weller Shives Laura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9830 Downsville Pike Hagerstown, Maryland 21 e of Disposition (Name of Date 20c. Location - City or Town, State Bernard Barnhart - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) Cedar Lawn Mem. Park June 18, 2009 Hagerstown, Maryland 4 Donation 21. Signature of Funeral Survice OSBOTTE ATUTE TELLY Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hours cerebrovascular resulting in death) Secuentially list conditions

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

**Funeral** 

**Director** 

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Meonce.

Directo

Funeral

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Completed by Physician/Medical

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Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed After n 24 hours after death.

le Funeral Director; Af
bletely filled in by the fur

Division of Vital Records, P.O. Box 68760,

rrany, leading to infineduale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <u>diabetes</u> Due to (or as a conseque	mellit	ريد		years
IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dead of the control of th	leath 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not result	ing in the underlying	cause given in Part I.		o use contribute to the cause of death?  2
				24a. Was an autopsy performed 1 \( \text{Yes} \) 2	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	DOA Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how in	njury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysiclan: To the best of my know niner: On the basis of examination and manner stated.	ledge, death occurr on and/or investigat	ed at the time, date and place on, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29h Signature and title of certifier		2	29c. License number	29d.	Date signed (Month, Day, Year)

D47 451

June 15, 2009

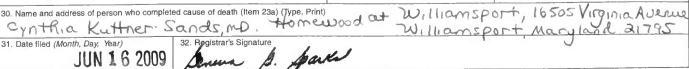
Williamsport, Maryland

05H-1

within 2.

State Registrar

31. Date filed (Month, Day, Year) JUN 16



Kuttner-Sand, and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 11, 2:50 A M Owen Ballew June William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery Hospice - Casey House Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 3, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 🔀 M 2 🗆 F 80 Kansas 559-32-1460 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2x ☐ No Funeral Director Maryland Montgomery Damascus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20872 U.S.A. or items 23a 24753 Cutsail Drive 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 XXYes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In an once. U.S. Navy Medical and XRay Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Plummer 0wen William Ballew ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24753 Cutsail Drive, Damascus, Maryland Pauline F. Ballew - Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematorium 6/12/09 Alexandria, Virginia 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Hovers Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. چ Lung Abscess with empyema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Atrial Fibrillation autopsy performed 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospice Hospital: 1∐Yes 2∏No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🛛 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Purporal Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 To the Hosp within 24 hor To the Fune completely fi

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cal

State Registrar

29b. Signature and title of certifier Kouercheu, ms Jocelyne

29c. License number 00063740

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

June 11, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchon, M.D. 6001 Muncaster Mill Road, Rockville, Maryland 31. Date filed (Month, Day, Year)

JUN 12 2009

determined

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

09-04549 Phi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ilip Barns	1	State of Maryland / Department - For State Certificate	of Health and Mental H	iygiene Reg. No	2009 2058
Physicia	R	tegistrar 1. Decedent's Name (First, Middle,Last)	0, 200	Date of Death     Month Day	3. Time of Death
edical Examii	31.0	Phillip A. Barnes		June 8, 2009	09051118
1		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death Anne Arundel
		701 Glenwood street, Apartment 513	Annapolis	1000	M/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $217-50-9343$ 1 X M 2 F	Months Days Hours Mi		Country)
	1	Usual Residence of Decedent			10d. Inside City Limits
any	- 1	10a. State 10b. County 10c. City, Town or Lo			1 XYes 2 No
and show	5	Maryland Anne Arundel Annapo		1100.0	Citizen of What Country?
Maryl 28a-1 d at 0	e le	10e. Street and Number	10f. Zip Code	109.	USA
3a or		701 Glenwood St. Apt 513	21401 Was Decedent of Hispanic Origin?	Specify Ves or No-	14. Race - American Indian, Black,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	era	11. Marital Status 1 Never Married 2 Married Armed Forces? 13	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.
r deat	Funeral Director	1 Yes 2 X No	Yes 2 X No specify:		Specify: Black
rs afte	2	or Dates:	edent's Usual Occupation (Give kind o		b. Kind of Business/Industry
2 hour "nate	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use re		United States
36 hin 7. than edical	nple	12th 0	Baker	i	Naval Academy
21215-0036  July be filed within 72 hours after Montal Hygiewith material", event, the Medical Examiner event, the Medical Examiner	Co	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	
21; be fill ental F irked	Be	John H. Barnes	Georg	inia Kin	area r, City or Town, State, Zip Code) 21061
O 21 should nd Me is ma	P	19a. Informant's Name/Relationship (Type, Print)  Samantha M. Elliott(Daughter)			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygievier tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once		Samantna M. Elliott(Daughtel)  20a Method of Disposition  20b 1914cq of D	isposition (Name of cemetery,	Date 20	Oc. Location - City or Town, State
Ore ges 1 a of He If it		1 X Burial 2 Cremation 3 Removal from State Memor:	isposition (Name of cemetery, or other place) ial Gardens 6	5-11-09	Annapolis, Md.
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr			2 Wine mu and Address of Fability Sc	ns Mortu	ary, P.A.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permit. It least to and breat Hydrontal Hygiers. In prortant: If item 27 is marked other than injury or other traumatic event, the Medical		1 - P #=00482	821 West St. A	Annapolis	, Md. 21401
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not e	nter the mode of dying, such as cardia	c or respiratory arrest,	, shock, or heart Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gastrointestinal Hemorrhage			Death
kaminer		or condition resulting in death)  Due to (or as a consequence of):			
	L	Sequentially list conditions,			
	ine	if any, leading to immediate cause. Enter Underlying Cause			
_ =	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit	a E	d			
be be sici	edical	UNPENDED AMENDED			23d. Date of delivery
376( ficate g phy s the b	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pre	egnancy	Month Day Year
Box 6876 death certificate the attending phy of for use as the l	icia	past 12 months?  4 Pregnant at time of death 5	Other (Specify)		
Bo)	1 2	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ords, P.O. B w requires that the de as been signed by the should be detached is			if the underlying cause given in restrict		2 No 3 Probably 4 V Unknown
S, F puires en sign lid be	Completed by	Diabetes Mellitus; Hypertension		24a. Was an	
cord law rec has bee 2 shou	ble			autopsy perform	ned? death?
Rec The la	e e		26.Place of Death (Ch	1 Yes 2	No 1 ✓ Yes 2 No
ital Rec ician: The s certificate rector, page	Be (	25. Was case referred to medical			tesidence 6 Other: Scene
f V; Physic er this	₽	1 Ves 2 No Impact of Leath 28a Date of Injury 28b. Til	me of Injury 28c. Injury at Work?		ow injury occurred
n of ' nding Ph h After t	<u> </u>	1 Natural 5 Pending (Month, Day,Year)	1 Yes 2 No	,	
ivision  or Attend after death Director:	icat	2 Accident Investigation 28e. Place of Injury - At home, farm	m, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rural Route Number, City
Division of Vital Records, the law requirers after death. After the the rectificate has been sheen in by the funeral director, page 2 should be led in by the funeral director, page 2 should the	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The that this certificate has been signed by the attending phy Tro the Finneral Directors. After this certificate has been signed by the safe help comminery filled in white finneral director, page 2 should be detached for use as the b.			h occurred at the time, date and place	, and due to the cause red at the time, date a	e(s) and manner as stated. nd place, and due to the cause(s)
To the within To the	Medical	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	Σ	29b/Signature and title oncertifier	O.C.M.E.		June 9, 2009
		(Colorlelly)			
		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201	
	State	31 Date filed /htms/h- Dev Year hoos 3. Registrar's Signature			
Reg		.	arkel		
DHMH 17 Rev 1	1/2001	ORI	GINAL		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 8:30 P M Butler N. Margaret 2009 June 9, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Surburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 78 Months Days 1 □ M 2 🗙 F Dec. 8, 1930 North Carolina Director 579-38-6497 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f shore Examiner interest or retified at XXYes 2 □ No Funeral Director Chevy Chase Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8700 Jones Mill Road United States 20815 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 1 □ Never Married 2 □ Married Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any lnjury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) Government Food Service Worker 12th 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be Flossie D. Abernathy Henderson R. Hill ٩ Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Capitol Heights, Maryland 20743 817 Balboa Avenue Margaret N. Butler/ Self 20b. Place of Disposition (Name of cemetery, crematory or other place) June Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State d National 17, 2009 Laurel, Maryla 22. Name and Address of Facility Stewart Funeral Home, Inc. Laurel, Maryland 4 Donation 5 Other (Specify) Maryland National ature of Funeral Sorvice 4001 Benning Rd. NE Washington, DC 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 Days Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria 68760 IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ី Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No 2 No 1 ☐ Yes Vital After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred n 24 hours after death.

Please Funeral Director: After the Funeral Director: After the letely filled in by the funeral Division 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 10, 2009 D 37891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvan Shi, MD 121 Congressional Lane # 409 Rockville, Maryland 20852 31. Date filed (Month, Day, Year) State JUN 1 5 2009 Registrar

4

12

09-04518 Michael L Boggs

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ichaei L Boggs		State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg. No.  2009 205
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last)  MICHAEL L. BOGGS, SR.  2. Date of Death Month Day Year June 6, 2009  3. Time of Death 2158 hrs
-		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral		Prince Georges Hospital Center  Cheverly  Prince George's  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MW/DD/YYYYY) 9. Birthplace (State or Foreign
Director		577-92-3302   1X M 2 F   47 Yrs.   Months   Days   Hours   Min.   Sept. 5, 1961   Wash., DC
any		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
<b>*</b>	ō	Maryland Prince George's District Heights
the Mary 3a or 28a- otified at	Director	10e. Street and Number 6501 Kenova Street 10f. Zip Code 20747 10g. Citizen of What Country? USA
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trannatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 2 X No 1 X Never Married 2 X No 1 X Never Married 2 X No 1 X Nover Married
urs after tural",	Ď	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or other trannatic event, the Medical Examitee.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)  11 Carpenter Self Employed
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Cor	17. Father's Name (First, Middle, Last)  Jesse  Boggs  18. Mother's Name (First, Middle, Maiden Surname)  Shelva  Trotter
MD 21 d 2 should Ith and Me n 27 is man	٩	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Eric Boggs (Brother)  2409 Senator Ave., District Hghts, MD 20747
ore, I		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State Crematory or other place)  20b. Place of Disposition (Name of cemetery, Crematory or other place)
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Riverdale Park  Donation 5 Other Specify:  Riverdale Park  Crematory  Riverdale, MD  22. Name and Address of Facility Jordan Funeral Service, Inc.
Ba Perm Depit Imp		4001 Benning Rd., N.E., Washington, DC 20019
Physician /Medical	10	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease  a. Cutting Wounds of Neck and Forearm  Approximate Interval Between Onset and Death
vaminer		Immediate Cause (Final disease or condition resulting in death)  a. CUTTING WOUNDS OF NECK and Forearm  Due to (or as a consequence of):
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):  Cliposes of all the this initiated of the control of the co
uted Id ransit	Examin	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.
18760, rtificate be executed ing physician and as the burial - transit	Medical	UNPENDED AMENDED
Box 68760, edeath certificate be the attending physic ed for use as the buried for the buried for use as the buried for the buried for use as the buried f		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specific)  23d. Date of delivery Month Day Year
Box le death the atte	<u>≥</u>	1 Yes 2 No 9 Unknown g Unknown
ires that the disagned by the libe detached	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
cords law requ has been	ompleted	24a. Was an autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Reysician: The his certificate director, page	Be Co	25. Was case referred to medical 26.Place of Death (Check only one)
1 of Vital ing Physician: . After this certi funeral director	유	1 Ves 2 No losses
tending tending death. tor: Af	ation	1 Natural 5 Pending Jun 6, 2009 Year) 2045 hrs 1 Yes 2 No Subject cut
Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	Suicide 6 Could not be determined Could not be determined Could not be determined Specify Vacant House 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Vacant House 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5819 Martin Luther King Highway, Seat Pleasant, MD
To the Hospital within 24 hours. To the Funeral completely filled	edical (	29a. Certifier (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To with To com	Med	and manner stated.  29b. Signature and title of cerifier  29c. License number  29d. Date signed (Month, Day, Year)
		Patrici Granic - Colletins O.C.M.E. June 7, 2009
22		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	ate	31. Date filed (Appth, Day Year)  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2009 11:35A 09 Jean Barnett-Davis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Co. Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😾 F 02-01-1944 Wash. D.C. 65 Director 577-62-3140 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be redified at 1 No 2 No Director MD Prince Georges Laure1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20724 USA 3115 Burning Springs Rd Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 □Yes 2 🙀 No Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It alway Injury or other traumatic event, College (1-4or 5+) Elementary/Secondary (0-12) Quality Coordinator Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Armstead Barnett Viola Carpenter ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3115 Burning Springs Rd Laurel, MD 20724 Jeanine Davis (Daughter) Laurel, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Mem. Park 06-16-09 4 ☐ Donation 5 ☐ Other (Specify) Landover, 22. Name and Address of Facility Ralph Williams, II Funeral 6503 Old Branch Avenue Service, P.A. Temple Hills, MD 20748 21. Signature of Funeral Service Licensee Service, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastic Colon Cancer **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** months Deep Vein Thrombosis - Left Leg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23d, Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Day Month in the past 12 months?
1 Yes 2 No 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cachexia, Pulmonary Embolism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an Sarcoidosis autopsy performed? yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated.

Registrar

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Supanich

29c. License number

D0065485

Hospital 1500 Forest Glen Rd S.S.MD 20910

29d. Date signed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midkeal Examiner must he and the once. Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

ò

Completed

Be

**Funeral** 

Director

the burial-transi ned by the sign. page 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed

after death. filled in by

within 24 hours a

To the Funeral I

completely filled

Division or Vital Records, P.O. Box 68760,

l cecella Burreal	./ Sister	1000	u Street	D.E.	wasningto	n, DC 2	0020
20a. Method of Disposition	20b. F	Place of Disposition (Na	me of	Date		cation - City or Tov	wn, State
1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	emetery, crematory or		June	l l		1
4 Donation 5 ☐ Other (Specif	v)	<u>Le</u> e's Cre	matory	17, 20	009 CT	inton, M	laryland
21. Sizva ure of Funeral Service Licer	ns e	22 Name a	nd Address of Facil	lity Stewa	rt Funera	il Home,	inc.
Man 2	& March	111 4001	Renning F	Rd. NE	Washingt	on, DC	20019
23a. Part1. Enter the disease, or com-	nlications that caused the deat						Approximate
shock, or heart failure. List only	one cause on each line.	_	1 3				Interval Between Onset and Death
Immediate Cause (Final disease or condition	Nas	Monas	oses				months
resulting in death)	Due to (or as a conseq	SALEKTION I					
	1 10	ma Can	CER	2			41).
Sequentially list conditions,	b. Due to for as a conse		- CC	_		1	
cause. Enter Underlying Cause (Disease or injury		()					J
that initiated events resulting in death) Last	c						
resulting in death) Last	Due to (or as a consec	uence ot):					
	d						
IF FEMALE:	23c. If yes, outcome pf pregn	ancy				23d. Date of delive	erv
23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	al death 3 ☐ Ectopic p				Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5 ☐ Other (s	pecily)				
					an Dillebass		a cause of death?
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part	t I.	23e. Did tobacco u		
					1 ☐ Yes 2[	□ No 3 Prob	ably 4 Unknown
				-	24a. Was an	24h Were auto	psy findings available
-					autopsy performed?	prior to con	mpletion of cause of
; }					1☐ Yes 2 No		2□No
25. Was case referred to medical			26. Plac	ce of Death (C	heck only one		
examiner? 1 ☐ Yes 2 🐼 No	Hospital: 1   Inpatient 2	TER/Outpatient 3 □ D	Other: 4 1	Nursing Home	5 Residence	6 □Other (Specif	y)
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at		. Describe how injur		
1 Natural 5 Pending	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐	¬No			
2 Accident investigatio 3 Suicide 6 Could not b					Leasting (Ctroot or	d Number or Pur	al Pouto Number
4 Homicide determined	e 28e. Place of injury - At h building, etc. (Speci	ome, farm, street, facto <i>fy)</i>	ry, office	281.	Location (Street are City or Town, State	e)	a noute vulliber,
29a. Certifier 1 Certifying P	hysician: To the best of my kn	owledge, death occurre	d at the time, date	and place, and	due to the cause(s	) and manner as s	tated.
(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/or investigation	on, in my opinion, de	leath occurred	at the time, date an	a piace, and due to	o trie cause(s)
29b. Signature and title of certifier	011	A 2	9c. License number	г	29d. Da	te signed (Month,	Day, Year)
	V 11 - V -	11 / 19	D 1/4/	19		-10-6	9
1 xemal	ADVIVOE	RL I JO	U UBTI		0	100	

State Registrar

21585 Peabody Street Leonardtown, Md.

20650

30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)

M.D.

Jarboe,

James/Patrick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year <u>01:10</u> a м **Physician** 06/10/2009 Jose Mario Jacinto Contreras /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 11☑ M 2□ F Guatemala 06/08/1977 Director None Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State Show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tre Modical Evandror must be retified at Yes 2□No Director Columbia Md Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Guatemala 21045 8734 Airybrink Ln Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Hispani.c 1 Yes 2 □ No Specify: Guatemala Specify: ⋛ Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Construction Labor 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked othnary injury or other traumatic event once. Be Elena Contreras Tomas Antonio Jacinto ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) a-5 Windson Castle, Cranbury, NJ. 08512 Rene Jacinto Contreras/Brother 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/17/09 Guatemala General Cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T Rhines Funeral Home re of Funeral Service Lic. nsee 21. Si mati 3005 12th St. NE Was. DC 20017 Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ediate Cause (Final years **Physician AIDS** se o condition u death) /Medical Due to (or as a consequence of): **Examiner** months Toxoplasmosis - Brain Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last months attending physician and for use as the burial-transi MRSA - Bacteremia Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown Alcoholism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has I director, page 2 s performe 1 ∐Yes 2 🕱 No 1 ∐Yes 2 XXNo 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA this Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

The law requires that the death certificate be executed んななななほ / 化 / M また また こり Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 12 2009

DHMH 17 Rev 1/2001

Registrar

Barbara Supanich, M.D. 1500 Forest Glen Road, Silver Spring, Md 20910

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sepanich FSM MD

29c. License number

D0065485

29d. Date signed (Month, Day, Year)

06-10-2009

amend #20b&c Per INF G893 7/02/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8 2009 **Physician** 1:33 P M NARCISO BEJAR CATAGAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY NATIONAL NAVAL MEDICAL CENTER
5. Social Security Number 6. Sex 7. Age (In yrs. last the BETHESDA If Under 24 Hr Birthplace (State or Foreign Country) birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 🖾 M 2 🗆 F 53 1956 Philippines Director 621-12-8460 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Germantown Maryland Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 72 hours after death with United States 23a 20874 13253 Country Ridge Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. 1 XYes 2 No 1988− If Yes, Give Year or Dates: 2009 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Aviator Structure Mechanic permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Catagan ပ Juan Carmen Beiar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13253 Country Ridge Drive, Germantown, Maryland 20874 Macaria D. Catagan/Wife 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Flored Dispession Chical Cem Hayward 1X Burial 2 ☐ Cremation 3 ☐ Bemoval from State Sacramente 4 □ Donation 5 □ Other (Specify) 6/19/2009 Dixon, California 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses MO///710 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** NON HODGKINS LYMPHOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed Examir burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as nse s IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 2 ☐ No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔽 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June, 9, 2009 Shrice 01055104A (IN) NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 MICHAEL BAYDARIAN LCDR MC USN 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 12 JUN Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8 Day Month 2009 11:24 PM **Physician** June Harriett H. Carney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunrise Assisted Living Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 125E Yrs. 100 22, 1908 Pennsylvania 166-18-8391 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examirer must be retified at 1 ☐ Yes 3√No Annapolis Anne Arundel Maryland Director the 1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 800 Bestgate Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e any injury or other traumatic event, the Medical Example must once. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. □Yes 2**/1**No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify White <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian M. Tracy Jacob L. Hinkle ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, Maryland 21403 998 Headwater Road Barbara Burroughs/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Thomas Church Cem. 6/12/2009 White Marsh, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Myslin T. Clobert 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure - end stage vears **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ cate has been sign, page 2 should be Breast Cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Mellitus, type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 22 No 2 🗆 No 1 ☐Yes certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Ssisted Liv 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

P.O. Box 68760. Division of Vital Records, after death.

I Director: Ald in by the fur filled in by To the Hospital o within 24 hours aff To the Funeral Di

9 D 1

> State Registrar

29a. Certifiei

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUN 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles P. Adamo, MD

and manner stated.

2629 Riva Road, #112 Annapolis, Maryland

32. Registrar's Signature

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

09-04663 William Michael	Clat	Please Typ	e or Print in ate of Maryla							gibl	e.			
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Physicia	in/	1. Decedent's Name (First, Middle						2	Date of De		Year	U 43	3. Time of Death	_
Medical Exami	ner	William Micha					1		June 12,	2009		Darette	0318 hrs	_
· **		4a. Facility Name (if not institution Route 214 and Fern Hi	-	imber)		4b. City, Town, Edgewate		of Death		- 1	c. County of Anne Aru			
Funeral			6. Sex	7. Age (In yrs. la	est birthday)	If Under 1 Y	ear If Unde		8. Date of B	Birth(MN	(/DD/YYYY)	9. Birth	place (State or Takoma Park	_
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	William Byrum					Diar	na L.	Clabu	ırn				
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Baltimore, MD permit Pages I and 2 sho Department of Realth and Important: If item 27 is injury or other traumat		Diana L. Clab  20a. Method of Disposition	ourn / Mo			heyenne sition (Name of			Date		Location -			_
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altin mit. P sartme nortan		4 Donation 5 Other Sp. 21. Signature of Funeral Service I				L Cemete			/2009				aryland ore Avenu	_
		H lonstar	ree S	aseh	Ga	sch's F	unera	1 Hom	e, P.A				, MD 20781	
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.		. Do not enter	the mode of dyi	ng, such as o	cardiac or r	espiratory a	rrest, st	nock, or hea	rt	Approximate Interv Between Onset an	
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D. Box 68760, tritle death certificate be ex by the attending physician ached for use as the burial	an//	23b. Was decedent pregnant in the past 12 months?	1 Live	birth	2 F	etal death	3 Ectopi	ic pregnand	су	_	Month	Da	ay Year	
Sox leath ce attende for use	Si	1 Yes 2 No 9 Unk		nant at time of de lown	ath 5 C	ther (Specify)								
O. E at the d 1 by the tached	, Phy	Part II. Other significant conditi		o death but not re	esulting in the	underlying caus	se given in P	art I.	23e. Did	tobacc	o use contri	bute to th	he cause of death?	-
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	d by								1 Y	es 2	<b>√</b> No 3	Proba	ably 4 Unknown	)
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed									opsy	р	nor to co	opsy findings availab Impletion of cause of	
Rec The la cate h	Ë									formed 2		eath? Yes	2 No	
Vital Rec ysician: The l his certificate l	Be	25. Was case referred to medical examiner?	Hospital:				Other	-	_	7				_
n of V ling Phys After this	£	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatier 28b. Time of		njury at Worl		Home 5 8d. Describ		dence 6		Scene	_
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	( 5.1.5 5.1.)	nysician: To the be miner:On the basis and manner:	of examination a										
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<b>●</b> 8		Potri U	MOI	let .	P	О.	C.M.E.			Ju	ne 12, 20	009		
		30. Name and address of person Patricia Aronica-Pollak		se of death (Item	,	111 Penn	Street R	altimore	MD 212	01				
		21 Date fled (41-1/2 C-1/2-1		paintraria Sianati		7777 61111			, 212					_

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			- For State Registrar	, , , , , , , , , , , , , , , , , , , ,	-	ent of Healt ate of Death			g. No. 200	9 2059
Ph Medical E	ysicia Vami	ın/	1. Decedent's Name (First, Mic	ddle,Last) Curtis				2. Date of Death Month June 5, 200	Day Year	3. Time of Death 0943 hrs
vicultai L	-Aaiiiii		Dominique  4a. Facility Name (if not institute)		er)	4b. City, To	own, or Location o		4c. County of Deat	
No.			3401 Floral Park Ro			Brand		- Odlika To Date of Diet	Prince Georg	e's rthplace (State or Foreign
	neral ector		5. Social Security Number 578-25-3530	6. Sex 7. A	Age (In yrs. last birth	Months				DC DC
	any		Usual Residence of Decedent  10a, State 10b. Count	у	10c. City, Town of	or Location	<del></del>			10d. Inside City Limits
and	28a-f show any 1 at once.	5	DC				lashingto			1 X Yes 2 No
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland	or items 23a or 28a-f shomust be notified at once.	Funeral	1 X Never Married 2	1 Yes	s? 2 X No			Puerto Rican, etc.)	White, etc.  Specify: B1	ack
ırs afte	tural",	2	3 Widowed 4 5. Decedent's Education (S	Divorced If Yes, Give Year or Dates: pecify only highest grade of		Decedent's Usual (			16b. Kind of Business	
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-003   within	ther th	E .	12th 17. Father's Name (First, Midd	le. Last)		-	Cashier 18.Mother	s Name (First, Middle, M		vate
215.	rked of	Be		Curtis				erri Mille		
D 21 should	is ma	٩	19a. Informant's Name/Relatio		19b			nber or Rural Route Num		
and 2	item 27	ŀ	Michael Cur			f Disposition (Nam		Drive Oxon	20c. Location - City of	20745 r Town, State
MOF	nt: If		1 Burial 2 X Cremat  Onation 5 Other	ion 3 Removal from	State	ory or other place) S Cremato	ry	June 11, 2009	Clinton, 1	
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 7	Department of reality and Meniar rygjene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	1	1. Signature of Funeral Serv		MITTER			Stewart Fu		
Phys			23a Parti, Enter the disease,		ed the death. Do no	t enter the mode of	Genning I f dying, such as c	Rd. NE Was	est, shock, or heart	Approximate Interval
/Me	dical niner	1	failure List only one cau Immediate Cause (Final disea	se a. Multiple Guns	hot Wounds					Between Onset and Death
***	IIIIIEI		or condition resulting in death	Due to (or as a co	nsequence of):					
		<u>la</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	Due to (or as a co	nsequence of):					
ted	1 ansit	Wedical Examiner	(Disease or injury that initiated events resulting in death) Las		nsequence of):	-				
) be execu	ician and ırial - tra	dical	UNPENDED	AMENDED						
Division of Vital Records, P.O. Box 68760, his or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1  Yes 2  No 9  ↓	1 Live birth 4 Pregnant	at time of death		3 Ectopic	c pregnancy	23d. Date of delive Month	ny Day Year
O. at the de	I by the tached f		Part II. Other significant con	1 9 Olikilowi		g in the underlying	cause given in Pa		bacco use contribute t	
S, D	n signed d be de	ed by								obably 4 Unknown
<b>Sord</b> law req	has bee 2 shou	Completed					_		rmed? prior to	completion of cause of
. Be	tificate or, page		25. Was case referred to med	ical			26 Place of Death	(Check only one)	2 No 1 🗸	Yes 2 No
Vita <sub>1ysicia</sub>	this cer I direct	To Be	examiner? 1 ✓ Yes 2 No	Hasnital:	atient 2 ER/O	utpatient 3 D	OA Other	Nursing Home 5		er: Scene
n of	h. After funera		27. Manner of Death  1 Natural 5 P	28a. Date of FOUND:	ry, Year) FOU	IND:	8c. Injury at Work	Subject shot	how injury occurred t	
risio r Atten	irector n by the	ficati	2 Accident In	vestigation Jun 5, 200	9 0923 f Injury - At home, fa			tc. 28f, Location (S		Rural Route Number, City
	ours aft teral Di filled ii	Certification:	4  Homicide	etermined (Specify)	ound in ditch i			- 1	Floral Park Road, B	
Division of Vital	hin 24 h <b>the Fur</b> npletely	Medical	29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the best of carniner: On the basis of c	examination and/or i	ath occurred at the nvestigation, in my	time, date and pla opinion, death of	ace, and due to the caus ccurred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
Ę.	To COIT	Med	29b. Signature and title of cer	and manner state	ea	290	License number		29d. Date signed (M	fonth, Day, Year)
				1			O.C.M.E.		June 6, 2009	
·R 3			30. Name and address of pers Mary G. Ripple MD.			111 Penn	Street, Baltim	ore, MD 21201		
7/- 3	S	tate	31. Date filed (Month, Day Ye		strats Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh g895 9-24-09 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** Albert Nathan Campbell May 29, 1921 hrs. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital Year 1928 9. Birthplace (State or Foreign Country) West If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**X** M 2□ F Jamaica, Indies 81 577-86-2119 February 10, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County fshow in than "natural", or items 23a or 28a-f show 1X Yes 2 □ No Takoma Park Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Jamaica, West Indies 20912 Seek Court 26 Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 □ Never Married 2 □ Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Landscape Gardener 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emelia **Bowers** Joseph Campbell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai once. 26 Seek Court; Takoma Park, Maryland 20912 Linda Gordon (Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. 9-14-09 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Service Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Mostate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 mont 5 Other (specify) 4 Pregnant at time of death s been signed by the should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 1 □ Yes 2**X** No 1 ☐ Yes 2 ☑ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only

State

DHMH 17 Rev 1/2001

Registrar

one)

29b. Signature and title of certifier

Sandeep Sharama,

MD

29c. License number

M.D.; 743 Summer Walk Drive; Gaithersburg, Maryland 20878

D0064624

29d. Date signed (Month, Day, Year)

June

OT, 2009

and manner stated.

32. Registrar's agnatu

30. Name an above s of person who completed cause of death (Item 23a) (Type, Print)

			State State Registra/MEND#17perFH, 6/23/09	of Maryland / E	-	rtment e tificate			and Me		giene Reg. No.	2009	2.0	591
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time o	
200	/Medic		4a. Facility Name (If not institution, give street and it	Da o		4b. City, To	wn orl	ocation o		June	10	209 County of Death		5 AM
أميي	Examin	ici	Manor Care Ruxton	,		Towson	,					ltimore	•	
	Funeral Director		5. Social Security Number 6. Sex 18 M 2 □ F	7. Age (In yrs. last birt	thday) Yrs.	If Under 1	Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day March 13	y, Year)	Cot	nplace (State Intry) am	or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Loc	ation							10d. Inside C	ity Limits
	Maryl.	tor	Maryland Baltimore	Lutherv										2 No
	h the or 28a	Director	10e. Street and Number			10f. Zip Co	ode				10g. Citiz	en of What Cou	intry?	
	ath will		7001 N. Charles St.			21204					USA			
940	permit. Pages 1 and 2 should b. "filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene." Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Midical Examination until perceited and once.	by Funeral	Armed	ecedent Ever in U.S. Forces? s 2 xNo Give Dates:		Vas Deceden Yes, specify □Yes 2□		panic Orig , Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	- 1	4. Race - Amer Black, White, Specify: Asia	etc.	
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d 2	Hiled Hygin		17. Father's Name (First, Middle, Last)	( ) B	Banke	<u> </u>		18. Mothe	r's Name (	(First, Middle,		anking Surname)		
C	Ald E. Mental	To Be	Tam Duc Dao						Thi B			,		
altimore, Maryland	2 short and 1 is ma	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing	g Address (S					r, City or	Town, State, Z	p Code)	
e, r	is 1 and 2 is 1 health a item 27 is other trau	1	Nhat Nguyen / daughter		22 1	ucky		tates		7 4 1 2	nvice,		22182	<u>k</u>
nor	Pages hent of the neutron of the neu		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from						Da 			ation - City or T		
altir	artme ortan Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Nationa	-	morial Name and A				18, 2009	Falls	Church,	VA	
ä	Depa Impo any Ir		PRO LIM						,	482 Lee	Hwy,	Falls Chu	rch, VA	22042
. ii	Physician		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition	t caused the death. Do not each line.		er the mode of	of dying	, such as	cardiac or	respiratory ar	rest,	Ą.	Approxima Interval Be Onset and	Death
	/Medical Examiner		resulting in death)	o (or as a consequence o		CV								.~
		er	Sequentially list conditions, b.	o (or as a consequence o	of).									
	cuted id ansit	Examiner	if any, leading to immediate cause. Enter Undert, in Cause (Disease or injury that initiated events	y (or as a somequence o	20).									
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S, F	w requires that s been signed to should be deta	by P	Part II. Other significant conditions contributing to	death but not resulting in	the un	derlying caus	e giver	in Part I.		23e. Did to	bacco us	e contribute to	the cause of	death?
ord	een si oould I	ted	Coronary Arte	ry Dire	205	e				1 🗆 Y	es 2	(No 3□ Pro	bably 4	Unknown
Y	The ate h	Completed	Congestive t	reart t	au	lure				24a. Was a autop perfor	sv i	24b. Were aut prior to c death?	opsy findings ompletion of	available cause of
<b>3</b>	nding Physician: th. : After this certifica e funeral director, p	Be	25. Was case referred to medical examiner?							(Check only o	ne)			
ō	y Physer this eral di	7: To	103 214(110	Inpatient 2 ER/Out e of Injury 28b. T	1		Other	4 X Nu		e 5  Resid		Other (Spec	ify)	
<u>0</u>	inding ath. r: Afte e fune	atior			njury	М 200.	Work?	ut es 2∐N		od. Describe i	low Injury	occurred		
DIVISION	ir Atte ter dea irecto	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buil	ce of Injury - At home, far ding, etc. (Specify)	m, stre	et, factory, of	fice		28	3f. Location (S City or Tow	treet and	Number or Ru	ral Route Nur	m <i>ber</i> ,
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:	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p.	fedical		ne best of my knowledge, basis of examination and inner stated.	, death d/or inv	occurred at t estigation, in	my opi	e, date an inion, deat	d place, au th occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(	s)
		Σ	29b. Signature and title of certifier			29c. Li	icense	number	200	2		signed (Month	, Day, Year)	
	5	-	30. Name and address of person who completed cal	ise of death (lies 00.)	Tura C	DC	10		283		Jur	-	200	24
			Richard O. Addo.	8415 B	ec ec	Long	7 4	ane	#	216,	TOW	son h	10 21	204
	Stat Registra		31. Date filed (Month, Day, Year)  JUN 1 2 2009	Registrar's Signature	par	K.				ι		1		•

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 Herbert Levi Dotson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. Sept. 25,1928 | Maryland 219-20-3459 Director 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Actical Examination state by an utility at 1 ☐ Yes 2 XNo Director Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number s 1 and 2 should be filed within 72 hours after death with is of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or U.S.A. 21742 1500 Pennsylvania Ave. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1) Yes 2 No If Yes, Give 1951 -Year or Dates: 1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriett Randall Dotson ဥ Ray Emerson Dotson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1309 Woodland Way Hagerstown, MD 21742 Eugene C. Dotson-son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages 1
Department of I
Important: If ite
any Injury or ot
once. Burial 2 Cremation 3 Removal from State 6-18-2009 Hagerstown, Maryland Cedar Lawn Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the v sease, or o implication that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiciar Completed by Physician/Medical as the IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month signed by the atter 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy 2 No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: d in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide n 24 houn. the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2

State Registrar

5H2+

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Wallworth

Western Manyland Hasputal Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monico StalworTH, MB

32. Registrar's Signature

Barras

29c. License number

DOO 5278

1500 Pennsylvannia Avenue, Hugus town, Md

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:00 P M Marlene Ruth Dowling 08 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Months 1 □ M 2 ▼ F 77 New Jersey 158-22-3853 06, 1932 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at Arnold 1 ☐ Yes 2 No Anne Arundel MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21012 851 Twin Harbor Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Alice Ward Lester G. Gerhard 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 851 Twin Harbor Drive Arnold, MD 21012 Drew Dowling / Husband Health item 27 i 20b. Place of Disposition (Name of Hilmorrest Methoritation 20c. Location - City or Town, State ne 13, 2009 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Annapolis, MD Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signitur of Funeral Struce Linens ranco & Sons, P.A. Severna Park Funeral Home Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) respirator **Physician** 4 cute weeks /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed Hemothorax that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical Cardiony IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) n signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No rillation 3 Probably 4 Unknown 1 🗌 Yes been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 st autopsy Gleedi 211No Gastrointestral After this certificate 1 □Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08 060390 ~0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADEEB ANNE ARUNDEL CENTER ANNAPOLIS JABER egistrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Ann D. Dammeyer 11:38 PM 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis 290 Cedar Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 12 F 578-48-6601 78 13, 1930 Washington, DC **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinatinust be notified at Maryland Annapolis Anne Arundel 1 ☐ Yes 200 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 290 Cedar Lane U.S.A. Completed by Funeral death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force
1 ☐ Yes 2 1 □Yes 2□No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Graves James W. Douthat ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other trainsne. 290 Cedar Lane Annapolis, Maryland John H. Dammeyer/husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory 6/9/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Myclin 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DRONAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 sl autopsy performed? 1 ☐ Yes 2 ☐ No 1815105 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

leral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled

ED

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

CPITES 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Huy #400

29d. Date signed (Month, Day, Year)

			1 - State Of Management of Man		epartment of I <i>Certificate of</i>			ene 2009	2059
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Coo Year	3. Time of Death
	/Media	cal	Rachel Davis  4a. Facility Name (If not institution, give street and number)		Ab City Town	or Location of Death		Day 2009 Year 4c. County of Death	2039 P M
	Examin Funeral Director	ier	Prince George Hospital Ce 5. Social Security Number 6. Sex 7. Ag $1 \square$ M $2 \square$ F	e (In yrs. last birth		Cheverly   If Under 24 Hrs.   Hours   Min.		Prince G	_
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryl I-f sho	tor	DC			ashington	1		1 X Yes 2 ☐ No
	th the	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	ntry?
	sath w		4407 Quarles St. N			20019		United_	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. 8d other than "natural", or items 23a or 28a-f show event, the Medical Evaniner rust be institled at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☒ If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No	Alspanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: B1	etc.
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pu	e filed al Hygi f other vent, I	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
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Mar	d 2 sh Ith and ?7 is m traum		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street				•
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imo	Page ment c ant: if ury or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Memor	Harmony <sup>ther pla</sup> ial Park	18.	une 2009	Landover	, Maryland
Balt	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic erone.		21. Sign sture of Funeral Scruice Ircens e	Tro	Name and Addre			Landover neral Home ngton, DC	20019
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1	/Medical Examiner		Due to (or as	a consequence of	):				
	B #	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of	):				
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68760,	tificate be executed g physician and as the burial-transit	al E	Due to (or as	a consequence of	):				
	± 5, 6 1	edical	d						
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Division of Vital Records,	vystcian: The law requir is certificate has been si director, page 2 should I	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
<u> </u>	lcian certifi ector	8	25. Was case referred to medical examiner?	v			th (Check only one)		
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Divis	i ji ate o	Certification: To			n, street, factory, office		City or Town,	ŕ	~
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and	death occurred at the ti or investigation, in my	me, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number	290	I. Date signed (Month)	Day, Year)
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0	2		30. Name and address of person who completed cause of de		,		-	0.705	
	<u>ک</u> Stat			Hospital		verly, Ma	aryland :	20785	
	Stat Registra		JUN 1 5 2009 June 10.	barre	7				

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Amend #20c per cemetery PGC 6/17/09 HH State of Maryland / Department of Health and Mental Hygiene For State Registrar 0599 Certificate of Death Reg. No./ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 9, 2009 2:00 P Doyle **Physician** Ε. May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Camp Springs 5312 Redd Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Dec. 1, 1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min Months 1 □ M 2XXF Washington, DC 85 577-20-9875 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show s 1 and 2 should be filed within 72 hours after death with the Maryla of Heatth and Mental Hygiene, the Act of the Act of San and Act of the Ac 1 ☐Yes 2 No Director Maryland Prince George's Camp Springs 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ÚSA 20748 5312 Redd Lane Funeral 14. Race - American Indian. Was Deceus. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 □ Yes ŽŽ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emil<sub>v</sub> King Raymond Н. Hays Sr. Pages 1 and 2 should be ment of Health and Menta ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Dovle / Son 3761 Stonesboro Road Ft. Washington, Maryland Department of Healt Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Virginia <del>Maryland</del> ¥⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery July 8, 2009 Arlington, 4 ☐ Donation 5 ☐ Other (Specify) George P. 22. Name and Address of Facility Kalas Funeral Home P.A. 21. Signature Juneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer nset and Deat Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Der cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: f yes, outcome of pregnancy
□ Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 5 Other (specify) Pregnant at time of death certificate has been signed by the rector, page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 3 Probably 4 Unknown 1 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home XX Residence 6 Other (Specify) Hospital: 1∐ Yes 2. XXXIo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) . License number 29b. Signature and title of certifier 30. Name and address of erson o completed cause of death (Item 23a) (Type, Print) mon/la State Registrar

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	Physici	an	1. Decedent's Name (First, Middle, Last)  Robert John Egan		1		2. Date of Death Month June	10, 2009 ar	3. Time of Death			
11/4	/Medic		4a. Facility Name (If not institution, give street and number	4c. County of Deat	10:00 PM							
- 1			330 Sheckells Road  5. Social Security Number 6. Sex 7. A	OWN  If Under 24 Hrs.	9 Date of Birth	Calvert	hplace (State or Foreign					
	Funeral Director		009-30-3437 X M 2 F	Hours Min.	8. Date of Birth (Month, Day,		untry) rmont					
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation	M	arch 13	, 1944	10d. Inside City Limits			
	e Mary Ba-f sh	Director	MD Calvert	Huntingto	own		1 □ Yes 2 No					
	be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Exacting a notal be notified at	I Dire	10e. Street and Number 330 Sheckells Road		10f. Zip Code 20639	)	10	g. Citizen of What Co USA	untry?			
	r death	Funeral	11. Marital Status 12. Was Deceden Armed Forces	?	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White				
036	urs afte al", or i	<u>م</u>	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	<sup>]№</sup> <b>1963-</b> : <b>1967</b>	1∐Yes 2∭∑No	Specify:		Specify: W	nite			
15-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	(Give		during most of work	ing 1	6b. Kind of Business/	Industry			
21215-0036	d withir giene. er than	Completed	Elementary/Secondary (0-12) College 1-4or	(5+)	DO NOT use retired ager	1)		Governmen	t			
Maryland	be de e	To Be (	17. Father's Name (First, Middle, Last)  James J. Egan			18. Mother's Name		ddle, Malden Surname) Rogers				
Mar	2 sho and is m		19a. Informant's Name/Relationship (Type. Print) Insun Egan (wife)					City or Town, State, MD 20639	Zip Code)			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo	sition (Name of natory or other place	Juné	Date 2	0c. Location - City or				
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Ba	Department of the services of		John F.	01464 Holmes 8:	125 South	ern Mary	e Funeral Land Blvc	Home Cal	wert. P.A. MD 20736			
	Physician /Medical Examiner			ed the death. Do not ent line. 31044e1 s a consequence of):	-	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death			
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O. Box	that the death certificate be ned by the attending physicia detached for use as the bur	Physician/Medical		2 Fetal death 3 at time of death 5	Ectopic pregnanc Other (specify)	sy		23d. Date of de Month	livery Day Year			
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of Vi	/sicl	To Be	examiner?	tient 2 ☐ ER/Outpatier	nt 3 □ DOA Oth		th <i>(Check only one</i> ome 5 <b>X</b> Reside	nce 6 □Other (Spe	ecify)			
	ding h. After fune	tion:	27. Manner of Death  1 Natural 5 Pending (Month, C	jury 28b. Time o lay, Year) Injury	Worl	ryat k? Yes 2 □No	28d. Describe ho	w injury occurred				
Division	or Atten after deal Director: in by the	Certification:	2 □ Accordent	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory,					ural Route Number,			
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	To the within 2 To the comple	Mec	and mainer		29c. Licens	se number	29	3d. Date signed (Mon	th, Day, Year)			
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dr	5+1		30. Name and address of person who completed cause of Arati Patel 110 Hos	death (Item 23a) (Type,	ad Pr	inco Fre	devick	MD	20678			
	Sta Registr		31. Date filed ( <i>Month, Day, Year</i> ) 32. Regit JUN 15 2009	death (Item 23a) (Type, Polytans Signature Cleneurs B.	parks	,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Johnson Fell 2009 8:00 A June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Manor Healthcare Northampton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 □ M 2 1 F Maryland 11 1918 91 Feb Director 207 07 0081 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Charles Town WV Jefferson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 25414 676 Tuscawilla Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: White Baltimore, Maryland 21215-0036 Specify ò 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur and injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail Clothing Store Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Jones David Llewellyn Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 676 Tuscawilla Drive Charles Town, WV 25414 Mary Gordon Thorpe/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 06/13/09 Woodbine, MD Gallie Mothes Cremation Service P.O. Box 784 21. Signature of Funeral Service MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consiglence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed 2 No 1 □Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the fu 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number title of certier 29b. Signature ar D57643 HITEN ShAH, ML 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5/03 redends 65 c Thomas
31. Date filed (Month, Day, Year) Thongen . Registrar's Signature State JUN 1 5 2009 parker Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Regist	rar	State of Ma	ai yiai k		rtificate			ionarriy	Reg. No.	200	9 2060	
	Physici	an	1. Deceden	t's Name (First, Middle,						2. Date of De Month		Year Year	3. Time of Death		
des.	/Medic	al		lie C. Guio	June 13  4b. City, Town, or Location of Death					13, 2009 Year 11:50 a M					
	Examin	er		la Maris	give street and number)				onium				Baltimore		
	Funeral					e (In yrs. k	ast birthday	If Under 1 Y		ider 24 Hrs.	8. Date of Bi (Month, D	ay, Year)	Co	thplace (State or Foreign	
	Director			36-0852	1□ M 🕵 🗆 F	77	Yrs.				08/11/	/1931		1	
	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits	
	Ba-fsh	ctor	MD	Balti	more	Ca	tonsv	ille						1 ☐ Yes 2 🔼 No	
	vith th	Dire		and Number				10f. Zip Co				9	en of What Co	•	
	eath v	eral	1 Sh	adyhill Co	12. Was Decedent	Ever in U.S	6. 13.	Was Decedent If Yes, specify	228 of Hispani	c Origin? (Sp	ecify Yes or N		ed Stat 4. Race - Ame		
9	after d	Fur		er Married 2 Marrie	Armed Forces?			If Yes, specify 1 ☐ Yes 2 ☑			Rican, etc.)		Black, White	e, etc.	
003	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	d by	3 X Wid	lowed 4 Divorced	Year or Dates:							, .		Mite	
15-	in 72 h "nate	Completed by Funeral Director		15. Decedent's (Specify only highest	grade completed)		16a. Deci (Give life.	edent's Usual C e kind of work d DO NOT use r	ccupation one during etired)	most of work	ing	16D. KIN	d of Business/	Industry	
212	d with giene.	Com	Elementa	ry/Secondary (0-12)	College (1-4or 5	)+)	Volu	nteer C						Association	
pu	be filed tal Hygi d other event, II	Be (		Name (First, Middle, L							(First, Middle		Surname)		
ryla	d Men narke natic	٩		Capetanak			40h Mail	ing Address (S			madaki:		Town State	Zin Coda)	
Ma	nd 2 sh ulth an 27 Is r r traur			nant's Name/Relationsh er J. Guidi			1	aronwoo						zip code)	
re,	of Hear		20a. Metho	d of Disposition		20b. P	lace of Disp	osition (Name o	of place)		Date	20c. Loc	cation - City or	Town, State	
<u>i</u>	Pages ment of ant: If ite ury or o			rial 2 ☐ Cremation nation 5 ☐ Other (Sp	3 □ Removal from State ecify)		John	's Ceme	tery	06/17			cott Ci		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinet must be notified at once.		21. Signatu	ire of Funeral Service L	icense M	01044	. 2	22. Name and A	ddress of F	acility Har	ry H. V	Witzk	e's Fan	nily F.H. Inc	
	402 40		23a, Part 1	Enter the disease, or o	complications that caused	d the death							t City,	Approximate	
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  LEUKEMTA												
	/Medical		resulting in		Due to (or as		uence of):								
	Examiner	۰	Sequentially list conditions, b.												
	uted j insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										0		
o,	e exectant and and rital-tra		resulting in	death) Last	Due to (or as	a consequ	uence of):								
68760,	rificate be executed ng physician and as the burial-transit	Medical		,	d										
		/Me	IF FEMALE		23c. If yes, outcome	of pregna	ncy					,	3d. Date of de	divery	
. Box	death cer e attendin id for use	Physician/	in the	lecedent pregnant past 12 months?	4 Pregnant a	2 ☐ Fetal death 3 ☐ Ectopic pregnancy							Month	Day Year	
P.0	uires that the de signed by the a d be detached for	Phys	9□∪	nknown	9 Unknown					2-41	aan Did	I tobago III	ne contributo t	o the cause of death?	
ds,	The law requires that the ate has been signed by the bage 2 should be detache	ξ	Part II. Othe	er significant condition	ns contributing to death b	out not rest	liting in the	underlying caus	e given in r	ап I.		_		robably 4 Unknown	
Vital Records,	: The law require cate has been si, page 2 should b	Completed		· · · · · · · · · · · · · · · · · · ·							24a. Wa	s an	24b. Were a	utopsy findings available	
Re	The lar	omp		,							auto	opsy formed? 2 <b>X</b> No	prior to death? 1 □ Yes	completion of cause of s 2 □ No	
/ital		Be C	25. Was ca	se referred to medical						Place of Deat	h (Check only				
of/	S S =	မ	1 ☐ Ye	s 2 No	Hospital: 1 ☐ Inpati		ER/Outpati	ent 3 DOA		☐ Nursing Ho	ome 5 Res		Other (Spe	ecify) HOSPICE	
on	ng ffel	tion	1 <b>K</b> Na 2 □ Acc	tural 5 ☐ Pending	(Month, Da	ay, Year)	Injury	м 200	Injury at Work? 1 □ Yes	2 □No	Zod. Describe	s now injury	Cocarros		
Division	r Atter er dea rector by the	Certification:	3 □ Sul	cide 6 Could n		jury - At ho tc. (Specif	ome, farm, s	treet, factory, of	fice			(Street and		tural Route Number,	
Ö	oital oi urs aft ral Dii				NV.						1			an atatad	
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		k only 2 Medical I	p <b>Physicia</b> n: To the best <b>xaminer</b> : On the basis of <b>CLILIONE</b> mer st	of examina									
	To the vithin To the comple	Me		ture and title of certifier	0 6	1		29c, L	cense num	ber		29d. Dat	e signed (Mon	th, Day, Year)	
				SHANG	20 CANT			$\mathbb{Z}$	1497	92		6	1/5/20	09	
(E	) NO				who completed cause of				m	MONTIN	MD 0	1002	_		
, J	Sta	te		CIE JONES, ed (Month, Day, Year)	. 32. Regist	rar's Signa	ture »	LLEY RD	. TI	MONTUM	, MD 2	1093			
	Registi			JUN T	2003 Jane	un	p. 1	parked							

June 13, 2009 11:50 a.m.

Millie Guidi

1 - For State Registrar

Physici /Medi		John F. Gainer, II	June	8ay 2	2009	11:00 P M				
Exami		4a. Facility Name (If not institution, give stre		r Location of Death		4c. County	of Death Arun	.do1		
Funeral	7	Anne Arundel Medic  5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	An If Under 1 Year		8. Date of Birtl			place (State or Foreign
Director	Н	357-16-4612	1 2□F 87	Yrs.	Months Days	Hours Min.	March March	, Year) 2, 1922	$\mathtt{I11i}^{Coun}$	nois.
and w		Usual Residence of Decedent  10a, State 10b. County	10c. City	Town or Loc	cation				1	0d. Inside City Limits
Marylk f sho	호	Maryland Anne Arund		Annapo						1 □ Yes 2 No
h the l	Directo	10e. Street and Number	.61	Ailliapc	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
23a c		1252 Pram Place			21403			United S	State	es
fiaryliand ZIZID-UU30 2 should be filed within 72 hours after death with the Maryland 2 and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, I'm Mydical Examinar must be notified at	Funeral	71. Wantar Status	Was Decedent Ever in U.S Armed Forces?	6. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Blace	e - Americ k, White, e	ean Indian, etc.
Z I Z I 3-0U36 d within 72 hours aft glene. r than "natural", or it in "wdical Expri-	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XiYes 2 ☐ No If Yes, Give Year or Dates: WW I	I 1	□Yes 2XNo	Specify:		Specify	. Wh	ite
5-0 72 ho natur	Completed	15. Decedent's Educati (Specify only highest grade co	ion ompleted)	(Give	lent's Usual Occup	during most of worki	na	16b. Kind of Bu	isiness/Ind	dustry
vithin ene. than "	dw	Elementary/Secondary (0-12)	College (1-4or 5+)	Sales	OO NOT use retired	d)	_	F1exib1	o Pac	kaoino
filed v Hygic Sther	Be Co	17. Father's Name (First, Middle, Last)	4	Sares	•	18. Mother's Name				Raging
yland ould be file Mental Hy arked oth	To B	John F. Gainer, Jr.			1	Minnie M	ildred	Smith		
baltimore, Maryliar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any hijury or other traumatic enonce.		19a. Informant's Name/Relationship (Type.	Print)		•	and Number or Rura			•	
e, IV 1 and Health em 27 ther tr		John F. Gainer, IV/S 20a. Method of Disposition				rkshire D	rive, K	ildeer,		
ages ant of l		1 🗗 Burial 2 □ Cremation 3 □ Rem	noval from State	-	sition (Name of natory or other plac	i			•	
baltimor  bermit. Pages Department of mportant: If its any Injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature → Fageral Service Licensee	Lake	emont Me	morial Gar . Name and Addre	dens: June : ss of Facility Geo	<u>12, 2009).</u> rge P	<u>Davidsonv</u> Kalas Fi	ille, uners	Maryland 1 Home
Deparmi Deparmi Impor	1	> /MMale				ons Islan				
		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Dulmono	ury .	embo	lism.				Onset and Death
/Medical Examiner		resulting in death)	ue to (or as a consequent	ence m):						
	je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):						
acuted nd rransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c								
. <b>BOX 06/00,</b> death certificate be executed e attending physician and d for use as the burial-transit		resulting in death) Last	Due to (or as a consequent	ence of):						
oo / oU, ificate be e> g physician ts the burial	dica	d								
box (ath certification)	sician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome of pregnar	ncy	1=			23d. Dat	te of delive	ery
		in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Ectopic pregnand Other (specify)			Мо	onth	Day Year
The law requires that the ate has been signed by the bage 2 should be detached.	Phy	9 ☐ Unknown  Part II. Other significant conditions contrib		lting in the ur	nderlying cause giv	en in Part I	23e. Did to	bacco use cont	ribute to t	he cause of death?
requires to the signer of the	d by		yamış to dodu oct not room	ang in the ar	ioonymg oaddo gir		1 🗆 Y		3□ Prob	
law req as beer 2 shou	lete						24a. Was	an 24b. 1	Were auto	psy findings available
The la	Completed							rmed?	prior to co death? 1 ∐Yes	mpletion of cause of 2 □ No
Of VICAL Physician: 1 rthis certifica ral director, pr	Be C	25. Was case referred to medical examiner?				26. Place of Death	1			
Physic rathis or	<u>۲.</u>	1 les 2140	pital: 1 Inpatient 2 E	R/Outpatien 28b. Time of		4 LI Nursing Ho		dence 6 Oth		fy)
ding th. Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	28c. Injur Wor	k? Yes 2□No	zou. Describe i	low injury occurr	ou .	
VIS rector by th	Certification:	a Ella IIII GEL Could not be	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S	Street and Numb	er or Rura	al Route Number,
ital or rral Di										
To the Hospital or Attending Physician: The law requires that the within 24 hours are death.  To the Funeral Director After this certificate has been signed by the completely filled in by the funeral director page 2 should be detach.	edical	29a. Certifier (Check only one)  1	<ul> <li>ian: To the best of my known;</li> <li>On the basis of examination and manner stated.</li> </ul>	vledge, death ion and/or in	n occurred at the tivestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as s and due to	stated. o the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	7 7		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
50		Stock	es un	)	125	8510		06/0	クチノ	109
10+1		30. N nd address o person who comp	oleted lause of death (Item	23a) (Type, I	Print)					
		Stephen 31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	AMC	para.				
Sta Registr		JUNIO 200	9 Senera	1. 1	and					
DHMH 17 Rev 1/2	2001			7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1 1 9

		1	For State	State	of Man			t of Health are e of Death	nd Men		ene 0	09	20604	
1	φ.		Registrar  1. Decedent's Name (First, Middle	, Last)						Date of Death		Year	3. Time of Death	
	Physicia /Medic		Emma Daniel Gray June 8, 2								2009	1801	7:10 A M	
	Examin		4a. Facility Name (If not institution					Town, or Location of			4c. County			
3/2	No. of	-	Gladys Spellman	Special 6 Sex		ospital in yrs. last birtl		Cheverly		Date of Birth	Pr.		George's	
	Funeral Director		5. Social Security Number 579–46–7948	1 ☐ M 2 🔀 F		0.5	rs. Months	Days Hours	Min	(Month. Dav.	Year)	Cou	th Carolina	
			Usual Residence of Decedent							111 10	1711			
	how		10a. State 10b. County		10	Dc. City, Town	or Location						10d. Inside City Limits 1 X Yes 2 □ No	
	Ba-1 e	cto	DC				101 7	Washingt	on	10	a. Citizen of	M/hat Cal		
	Mith th	Dire	10e. Street and Number	Ctmoot C	E.		10f. Zip	2002	20				states	
	eath na 23	Funeral Director	1908 17th	12. Was D	ecedent Eve	er in U.S.	13. Was Deced	lent of Hispanic Origi	in? (Specify	Yes or No-	14. Rad	ce - Amer	rican Indian,	
0	ritter d	Fun	1 Never Married 2 Marr	ied 1 ☐ Ye	Forces?		If Yes, spec	offy Cuban, Mexican,	Puerto Hica	an, etc.)		ck, White $y_{c} \cdot B1$		
3	ours a	d by	3 XWidowed 4 ☐ Divorced	If Yes, Year o	or Dates:									
5	"natu	Completed	15. Deceden (Specify only higher	t's Education st grade complete	ed)	16a.	Decedent's Usua (Give kind of wor life. DO NOT us	k done durina most	of working	1	6b. Kind of B	lusiness/l	industry	
V	within ene. than	ошо	Elementary/Secondary (0-12)	Cofleg	e (1-4or 5+)			airwoman			G	over	nment	
2	Hygi other ent, I	Be Co	17. Father's Name (First, Middle,	Last)			OII.			irst, Middle, M				
<u>8</u>	uld be Aental rked tic ev	ToB	Mille	dge Dani	el				Li1	lie Ni	cholso	n		
<u>a</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itama 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations				•	(Street and Number					7/1	
≥ *`	and seath m 27		George Gray/	Son			L4 67th Disposition (Nar.	Avenue H			Maryla Oc. Location		20784 Town, State	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 172 hours after 33a or 28a-1 ehow impartment of Health and Mental Hygiene I have transfer at the which the I have seen injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation			cemeter	y, crematory or o	ther place)	June 5, 200	2			Maryland	
Saltimor	it. Partmer artmer ortant injury	1	4 □ Donation 5 □ Other (S			LILLIC		d Address of Facility	-	_				
ם מ	Dep Impo	5 4	John 1.	Stew	int.	111_		enning Rd				-	20019	
40			23a. Part. Enter the disease, or shock, or heart failure. List	complications th	at caused th	e death. Do n	ot enter the mod	e of dying, such as o	cardiac or re	espiratory arre	st,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			Failur	e						Onset and Death 4 Weeks	
	/Medical		resulting in death)	a.		consequence								
	Examiner	<u>_</u>	Sequentially list conditions, if any, leading to immediate	D		c Leuk							2 Years	
	ted nsit	Examiner	Cause (Disease or injury	< □	10 (01 40 4 0	,0,1004001100	.,,							
,	execun n and ial-tra	Exal	that initiated events resulting in death) Last	C. Due	to (or as a c	consequence	of):							
0 / B	certificate be executed iding physician and use as the burial-transit	dlcai		d										
٥	ntifica ing ph e as th	Med	IF FEMALE:											
X Q	death ce le attendi	lan/	23b. Was decedent pregnant in the past 12 months?	1□Li		Fetaf death	3 DEctopic p					ate of del Ionth	ive <i>r</i> y Day Year	
	that the death certific ed by the attending p detached for use as	Physiclan/Me	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		regnant at tin nknown	ne or death	5 Other (sp	ectry)						
<u>,</u>	requires that the een signed by th hould be detache										acco use cor	use contribute to the cause of death?		
rds,	w requires that been signed k should be det	q pa	Congestive Hea	rt Failu	re					1 □ Y€	s 2□No	3 🗆 Pr	robably 4 🛣 Unknown	
Vital Record	aw is b	Completed by								24a. Was a autops	v	Were au	utopsy findings available completion of cause of	
ř	The ete h page	Com								perform	ned? (Z) No	death?	2 □ No	
<u> </u>	ician: Th certificete rector, pag	Be	25. Was case referred to medica examiner?	Hospital						Check only on				
0	Phys this ral dii	7	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. D	Inpatient ate of Injury	28b. T	tpatient 3 DC			5 Reside			icify)	
0	ding th. After	tlon	1 XNatural 5 ☐ Pendi	//	Month, Day Y	/ear) li	n <del>j</del> ury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ N	No					
Division	If or Attending Patter death.  Director: After it in by the funerations	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningd 200. F	lace of fniury	/ - At home, fa	rm, street, factor	y, office	28f	Location (St City or Town	reet and Nun , State)	nber or Ri	ural Route Number,	
	spital or A ours after herat Dire filled in by	Cert						<u></u>						
	Hos Fur ely	edical	29a. Certifier 1 X Certifyi (Check only 2 Medical	Examiner: On the	the best of a basis of earner state	xamination an	, death occurred d/or investigation	at the time, date and i, in my opinion, deat	d place, and th occurred	d due to the ca at the time, d	ause(s) and nate and place	nanner as , and due	s stated. e to the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certific		namer state	1 1 26	29	c License number		2	9d. Date sign	ed (Mont	th, Day, Year)	
)	٤٦٤∀			( ())	M	NO		D 16273	3		6,	18/	109	
	5		30. Name and address of persor	who completed	cause of dea	ith (ftem 23a)	(Type, Print)				-	1		
_	<u> </u>		Revathy Murph					Cheverly,	Md.	20785				
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year IIIN 1 5 2009	Beens	z. Hegistari	s Signature					•			
1967.0		-	L LINE A U SUU	1		* #								

DHMH 17 Rev 1/2001

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Endicate Essania entitled a ponce.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

	1 - State Registrar	Reg. No. 2009 2060												
	1. Decedent's Name (First, Middle, Last)		Date of Death     Month     Day     Year     3. Time of Death											
ian ical	Geneva Granger		June 6, 2009 0257 A <sup>M</sup>											
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th 4c. County of Death											
	Southern Maryland Hospital	Clinton	Prince George's											
	5. Social Security Number 6. Sex 7. Age (In yrs. & 1 M 2 N F 9	Months Days Hours Mir												
	Usual Residence of Decedent		pary 4, 1919   0001g1a											
	10a. State 10b. County 10c. City	y, Town or Location	10d. Inside City Limits											
cto	Maryland Prince George's	Temple Hills	1 X Yes 2 □ No											
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?											
	3903-21st Place	20748-4325	United States											
Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	<li>S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li>	Specify Yes or Norto Rican, etc.)  14. Race - American Indian, Black, White, etc.											
by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	1 ∐Yes 2 XNo Specify:	Specify: Black											
etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry											
Be Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired) Dietician	Private											
e C	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maiden Surname)											
P	Prince Sims	Gene	va Reid											
	19a. Informant's Name/Relationship (Type. Print)  Janice Landrum/ Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 3903–21st Place Temple Hills, Md. 2074													
		lace of Disposition (Name of	Date 20c. Location - City or Town, State											
	1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)    Commettery   Crematory or other place)   June													
	21. Signature of Funeral Service Accepted 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019													
	23a. Part 1. This the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.  Approximate													
	shock, in heart failure. List only one cause on each line.  Interval Between Onset and Death													
	disease or condition resulting in death)  Due to (or as a consequence)													
	SACRAL	DEWBITUS												
ner	Sequentially list conditions, if any keeping to himself also conseque cause. Enter Underlying													
Cause. Enter Onderlying Cause. Disease or injury that initiated events resulting in death) Last  C. DYSPHAGIA  Due to (or as a consequence of):														
Medical Examiner	resulting in death) Last  Due to (or as a consequence of):  HYPERTENSION													
edic	d													
-	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	ncy	23d. Date of delivery											
Completed by Physician	in the past 12 months?		Month Day Year											
hys	9 ☐ Unknown													
y P	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?											
ed	ANEMIA		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown											
plet			24a. Was an 24b. Were autopsy findings available prior to completion of cause of											
MO.			performed? death?											
Be (	25. Was case referred to medical examiner?	26. Place of D	eath (Check only one)											
2	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ I	ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)												
tion:	Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury M 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred											
lical	3 Suicide 6 Could not be	me, farm, street, factory, office	28f Location (Street and Number or Rural Route Number											
Sertif	4 ☐ Homicide determined building, etc. (Specify	()	28f. Location (Street and Number or Rural Route Number City or Town, State)											
Medical Certification: To	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)											
	KASHEGAT BASSI . A	MD 653	29 JUNE 9TH 2009.											
	30 Name and address of person who completed galse of death (Item	SURRATTS ROAD.	29 JUNE 9TH 2009. CLINTON MD 20735.											
ate	31. Date filed (Month, Day, Year)  32. Registrar's Signat  JUN 1 1 2009	ture	CO 100 - 11/2 - CO 100 -											
rar	MANTITION COMPANY NO. 18 10.													

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 8:00 PM June 14 Hake Alice Dora 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Asbury-Solomons Health Care Center Solomons If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/20/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Days 1 ☐ M 2 🛛 F PA 91 214-44-6397 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 1 ☐ Yes 2 🛣 No Calvert Solomons 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 11450 Asbury Circle #306 20688 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Corrine Hess Milton Diamond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 89 W. Green Street, Westminister, Maryland 21157 William Hake (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Metropolitan Crematory 6/15/09 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Rausch Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee P. O. Box 600, Lusby, Maryland 20657 St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Y FARS HEART a. CONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): CORONARY ARTERT Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □ Yes 2 THO 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran physician a Division of Vital Records, P.O. Box 68760, attending ph the signed by has e 2 s page certificate After 1 death. Director:

**Physician** 

/Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be required a once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Physician/Medical 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 Yes 2 Ho Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) Injury 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

e Funeral I

within 2.

31. Date filed (Month, Day, Year) State Registrar

WEIGH, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 2009

PRINCE FREDERICK, MY-20678

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ecords, P.O. Box 68760,	aw requires that the death certificate he executed
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Division of Vital Records, P	To the Hospital or Attending Physician: The law requires that the d

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	•	State Registrar				Ce	ertificate of	Death	Re	eg. No. 🤈	nno	20607
Physicia		1. Decedent's Name	e (First, Middle, Mary A	·					2. Date of Death Month June 7	Day	Year	3. Time of Death  6:45 P M
/Medic Examin				give street and number)			4b. City, Town, o	r Location of Death		4c. County		lvert
Funeral Director		5. Social Security N 435–22–5	lumber 6		je (In yrs. 84	<i>last birthday</i> Yrs.			8. Date of Birth Month, Day, 04/23/	Year) 1925	9. Birthp	place (State or Foreign
ס		Usual Residence of			10c. Cit	y, Town or L	ocation		01,00,1			0d. Inside City Limits
e Maryl	Director	MD	Calver	t		mons						1 ☐ Yes 2 📉 No
h with the		10e. Street and Nur 13325 Do		ad			10f. Zip Code 20688		1	0g. Citizen of V USA	What Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: I flee 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination instituted at once.	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2☐ Married	12. Was Decedent Armed Forces? d 1 □Yes 2 1 If Yes, Give Year or Dates:	Ever in U. No	S. 13.	Was Decedent of Hif Yes, specify Cubin 1 □Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		ce - Americ ck, White,	etc.
nin 72 hou	Completed			Education grade completed) College (1-4or t	5.1)	i (Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	king	16b. Kind of B	usiness/In	dustry
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should be file and Mental Hy marked othur umatic event	To Be (	17. Father's Name (First, Middle, Last) Sam Martin							e (First, Middle, Nee Gordon		ne)	
ind 2 sho alth and 27 is m		19a. Informant's Na Mark Hene					ling Address <i>(Street</i> <b>Towers</b> Ba			•		,
Pages 1 and nent of Health int: If Item 27 iry or other to			•	Removal from State	Sou		osition (Name of matory or other place K <b>Cemeter</b>	y Jun	Date	20c. Location Pearla	- City or To	wn, State
permit. Departr Importa any inju		21. Signature of Fu	uneral Service Lic	Gary G	off	2	22. Name and Address Sout			l Home	Calv	vert. P.A. MD 20736
Physician		shock, or hea Immediate Cause	ırt failure. List or (Final	omplications that cause ily one cause on each li	ne.	h. Do not er	nter the mode of dyi	ng, such as cardiac				Approximate Interval Between Onset and Death
/Medical Examiner		disease or conditio resulting in death)	on f	Pa. ALZI Due to (or as			DISEA	36				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the team.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 3  Ectopic pregnancy 1  Other (specify)  Month										ery Day Year
w requires that the de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?										1 -
The law rectate has bee page 2 shou	Completed							-	24a. Was a autops perforr 1 □ Yes	y ned?_	prior to co death?	opsy findings available impletion of cause of
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Physical dire	<u>د</u>	1 Yes 2					ent 3 DOA Oth	4 Da Nursing H	ome 5 Reside			fy)
ending eath. or: After the funer	cation	27. Manner of Deat  1 Natural  2 Accident	5 ☐ Pending investigat		ay, Year)	28b. Time Injury	M 1 🗆	ryat k? ]Yes 2 □No	28d. Describe ho	w injury occur	rea	
tal or Attributed all Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide	determine	28e. Place of In building, el	ury - At ho c. <i>(Specif</i>	ome, farm, s	treet, factory, office		28f. Location (St City or Town		ber or Run	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; p	Medical	29a. Certifier (Check only one)	Certifying	Physician: To the best caminer: On the basis of and manner st	of examina	wledge, dea	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	e, and due to the corred at the time, d	ause(s) and mate and place,	anner as and due t	stated. o the cause(s)
To the within To the company of the	M	29b. Signature and	us a.	Mad, re	0			233		9d. Date signe	08/2	009
eu 5			ress of person wh	no completed cause of o	death (Iten	n 23a) (Type	Print) NCE FR	EPERICK.	MO	206	70	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 113 AM M **Physician** /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** awa 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6 Sex **Funeral** 1 ☐ M 2 💢 F Months Hours Director 219-14-8682 28.1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location. show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, trainvolon Example and the 1 Yes 27 No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 U.S.A. 13714 Emily St. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 TNo Specify þ White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than' Elementary/Secondary (0-12) College (1-4or 5+) Board of Education <u>Cafeteria Worker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecil Leroy Harbaugh Carrie Elizabeth Hause Harbaugh ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Hull-son 1335 West 15th St. Tempe, AZ 85281 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a, Method of Disposition Pages nent of I 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-19-2009 Cedar Lawn Mem Park Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee a 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-tran Due to (or as a consequence of) P.O. Box 68760 physiciar the death certificate be Physician/Medical signed by the attending p IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes No WOODIN certificate 1 ☐ Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica director, W case examiner? Be fer d to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Funeral Director: After th completely filled in by the funeral. 27 Manner of eath 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

15H-15

State Registrar

31. Date filed (Month, Day, Year) JUN 17

BARON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 14110 15 Richard Hoffman Joseph 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Washington County Hospital Birthplace (State or Foreign Country) Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Months 1**,** M 2□ F Yrs. Maryland Oct 27, 57 220-54-4709 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Hagerstown Maryland | Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 111 East North Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 1 ☐ Never Married 2 Married 1 ☐Yes 2 X No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Richard Hoffman Sr. Francine Fair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) East North Ave. Hagerstown Maryland 21740 Mary Lee Hoffman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory 6/17/2009 | Smithsburg, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licent 1601 Pennsylvania Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (0 dgs Sepa disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □No allites 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

State

Registrar

filled in by

completely

24 hours a

within 2

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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"natural", or

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permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other

death v

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar signed by the attending physician be detached for use as the buria is certificate has been s director, page 2 should this funeral After after death.

Records, P.O. Box 68760,

Division of Vital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chanic ohti 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29c, License number

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29d. Date signed (Month, Day, Year)

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HACERSTOWN

2009

MD 21740

3H-4

DATTA MO 31. Date filed (Month, Day, Year)

JUN 17

CM THE

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

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			For State Registrar Amend#26.PenP	State of M	aryland	d / Depa	artment of h	Health and			200	9 206		
			1. Decedent's Name (First, Middle, Las	y)	GU-15-	V.C.			2. Date of De			3. Time of Death		
	Physici		ANNIE ROGE	ERS HARV	EV				JUNE 5	, 200	Year 1 <b>0</b>	5:30 a <sup>M</sup>		
0.1	/Medio		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Dea		4c. County of Death				
- A	2,000	•	2324 BARKLEY PLACE	7			FORES	IVILLE		PRINCE GEORGES				
	Funeral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth	9. Birth	place (State or Foreign		
	Director		242-42-0406	□M 2 <b>X</b> F	82	Yrs.	Wionitis Days	Tiodis Will	JUNE 4			TAIN, N.C.		
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10a City	Town or Lo	nation					10d. Inside City Limits		
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	28a-f	ect	10e. Street and Number		WA	ASHING				10a Citiz	en of What Cou			
	er death with the Marylan items 23a or 28a-f show wr must be notilled at	급		<b>a</b> E			10f. Zip Code	2040			шу			
	sath	era	1302 44th PLACE,	12. Was Deceden	t Ever in II S	101		0019	Specify Vas or N		U.S.A.  14. Race - American Indian,			
215-0036	<b>5</b> of	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces  1 Yes 25  If Yes, Give Year or Dates	? ] No		Was Decedent of H f Yes, specify Cub 1 □Yes 2 🛣No		rto Rican, etc.)		Black, White,			
2-0	72 hours "natural",	ted	15. Decedent's Edu (Specify only highest grad	ication	-	16a. Dece	dent's Usual Occup	nation	arking	16b. Kin	d of Business/Ir	idustry		
21	within 7 iene. <b>than "r</b>	힐	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)	orking					
21	ed wi ygier ygier t, th	S		4		REGI	STERED N	-			RIVATE			
nd	be file d oth even	Be	17. Father's Name (First, Middle, Last)	D = =====				18. Mother's Na Elizab	ame <i>(First, Middle</i>		Surname) lock			
7/8	yould y Mer narke	은	Emmanuel	Rogers	1									
Maryland	f2 sh h and 7 is n traun		19a. Informant's Name/Relationship (7)		_		ng Address (Street			-				
	Healt Healt Fm 2		EUDORA L. HARVEY - 20a. Method of Disposition	- DAUGHIL			BARKLEY I	·	Date		ation - City or T			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, Itan Medical once.		1 XBurial 2 ☐ Cremation 3 ☐		<b>≓</b>		sition (Name of natory or other place				•			
뜶	it. Per urtme urtme urtant	1	4 □ Donation 5 □ Other (Specify		ARLI		NAT L CE					VIRGINIA		
Ba	permi Depai Impor any Ir		21. Signature of Funeral Service Licens		11		0583 MIDI							
			23a Part 1 Enter the disease or comp	lications that cause	ed the death						THIME	Approximate		
		r 73	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each	line.					arroot,		Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	a(A	1010	PULT	nonne	( ANA	57					
4	Examiner			Due to (or a	s a conseque	ence of):	141	na						
		-	Sequentially list conditions,	b. Due to (or a	s a conseque	ence of):	Cruq							
	uted ansit	ᄪ	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,										
Ć.	ate be executed hysician and the burial-transit	<u>ш</u>	resulting in death) Last	Due to (or a	s a conseque	ence of):								
760,	te be ysicia e bur	cal		d										
68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	ledi												
Вох	th cel	Physician/Med	Zob. was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			☐ Ectopic pregnanc	PV.		2	3d. Date of deliv			
Э. В	ed for	Sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant 9 ☐ Unknown	at time of de		Other (specify)	, y			Month	Day Year		
P.0	at the	h	9 □ Unknown \											
Ś	es th igner	ρ	Part II. Other significant conditions co	ntributing to death	but not result	ting in the u	nderlying cause giv	en in Part I.	11.			the cause of death?		
Records,	w requir s been s should	Completed							. 1	Yes 2	]No 3∏ Pro	bably 4 Unknown		
ec	law lasb 2 st	ple							24a. Was	psy	24b. Were aut	opsy findings available ompletion of cause of		
E F	: The law cate has l page 2 s	Co							perf 1 □ Yes	ormed? 2 ZiNo	death? 1 ☐ Yes	2 No		
Vital	nding Physician; Th. th. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Janutal.			100		eath (Check only	one)				
of	Phys this all dir	2	THES ZLING	-07	tient 2 E		I 3 L DOA					ify Daughter's		
	Jing After fune	io	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of In (Month, D	ay, Year)	28b. Time of Injury	Wor	k?	28d. Describe	now injury	occurred			
Sic	l or Attending after death. Director: After I in by the funer	ical	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Ir	niury - At hon	ne farm str	eet, factory, office	Yes 2□No -	28f Location	(Street and	l Number of Ru	ral Route Number,		
=	r jig e	Certification:	4 ☐ Homicide determined	building, e	etc. (Specify)	)	oot, lactory, onloc			wn, State)		arriodic rearrisor,		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  12 Certifying Phy 2 Medical Exam	rsician: To the besiner: On the basis and manners	of examination	/ledge, deatl ion and/or in	n occurred at the ti vestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)		
	Vithir Comp	Me	29b. Signature and title of certifier	~ ^			29c. Licens	se number		29d. Date	e signed (Month	Day, Year)		
			> Tend	177	30 Ce		D	2428	9	(	dul	2018		
n	~	1	30. Name and address of person who c		death (Item :	23a) (Type,					1			
<u>_</u>	2		DR. DAVID ISSAC -	5801 ALI	ENTOWN	RD.,	SUITE 5	10 CAMP	SPRINGS,	MD	20746			

State

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N	lental Hyg	giene	00611
			Registrar Certificate of Death	2. Date of Dea	Reg. No. 2	2061
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Catherine E. Harrod	Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	June 3	3, 2009 4c. County of Dea	
نگرست	Examin	er	Prince George's Hospital Cheverly		,	George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign
	Director		578-30-3409 1 M 2 XF 82 Yrs. Months Days Hours Min.	Sept. 20	, 1926 Mas	sachusetts
	pur 🔥		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	faryla f sho	ō				1 X Yes 2 □ No
	the N	Directo	Maryland   Prince George's   Capitol Heights  10e. Street and Number   10f. Zip Code	1	10g. Citizen of What Co	ountry?
	3a or		622 Clovis Avenue 20743		United	States
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amo Black, Whit	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination is stable retified at once.	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 3 Married 1 Yes 2 M No If Yes, Give 1 Yes 2 M No Specify: Year or Dates:	Tricari, etc.	ack	
Maryland 21215-0036	2 hou atura	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	/Industry
215	hin 7	Jple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ing		
2	ed wit ygien ier th	Completed	2 Personal Aide		Governm	ent
n	be filk d oth even	Be			Maiden Surname)	
3	ould d Mer narke natic	မ		Ethel To		T. 0 ()
Mai	d 2 st th and 7 Is r traur		19a. Informant's Name/Relationship (Type. Print)  Kathleen Amegashie/ Daughter  622 Clovis Avenue Capi		-	20743
ည်	1 an Heal tem 2		Kathleen Amegashie/ Daughter 622 Clovis Avenue Capi  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  July 10 Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
altimore,	Pages ent of nt: If i		1 A Buriai 2 Li Cremation 3 Li Removal from State	ne , 2009	Laural	Maryland
ቛ	mit. F partm portar Injur		4 □ Donation 5 □ Other (Specify) Maryland National : 11 21. Signature of Funeral Service Licentee 22 Name and Address of Facility Sto			
Ö	Per m m g		Maring Rd. 1			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition Cerebrovasular Disease			Onset and Death
ar i	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	Lxammer	<u>.</u>	Sequentially list conditions, b. Coronary Artery Disease			
	ted nsit	nlne	Tany bed. To an edicte cause. Enter Underlying Cause. (Disease or injury Hypertension			
	execu n and al-tra	Examiner	that initiated events resulting in death) Last  C. Hypertension  Due to (or as a consequence of):			
68760	ificate be executed g physician and as the burial-transit	edical	d. Diabetes Mellitis			
		/ledi				
Вох	eath certific attending p for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
о. Е	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months?  1 □ Yes 2 MNo 9 □ Unknown  1 □ Live billin 2 □ Felatioeath 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		Month	Day Year
ď	w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute t	o the cause of death?
ds,	signe d be o	d by	Hyperglobuliemia	1 🗆 Y		robably 4 🗆 Unknown
Ö	v requ	etec		24a. Was a		
Ř	: The law cate has page 2 (	Completed		autops	sv prior to	utopsy findings available completion of cause of
ta			25. Was case referred to medical 26. Place of Deat			s 2 🗆 No
>	ysician: is certific director,	o Be	examiner?		ence 6 Other (Spe	acify)
0	ding Phys h. After this funeral di	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ow injury occurred	,,,,
<u> </u>	Attendlr death. ctor: Af y the fur	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Att fter de ilrect	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or Fi n, State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and manner a	as stated.
	n 24 h	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, o	date and place, and du	e to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier)  29c. License number		29d. Date signed (Mon	th, Day, Year)
			Motifies MD 004667	/	06/09/	2009
R	-5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PIOTR L. GROTEC M.D.; GYOO Man (borto Pile 2)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	chief	Herolite +	10 20747
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	71-101	1,17	, ,
	Registra	2.0	111N 1 1 2009 1 A fines			

			Please	Type or Prin					_			
			For State	State of Ma	aryland / Depa	artment of H <i>rtificate of L</i>			0000	20512		
			Registrar  1. Decedent's Name (First, Middle, Li	ast)	Oei			2. Date of Death		3. Time of Death		
	Physici /Medio		Norman Hai	zlip				June 8	, 2009 Year	19:25 PM		
	Examir		4a. Facility Name (If not institution, gi				Location of Death		4c. County of Dear			
	Funeral		Washington Adve		Ltal e (In yrs. last birthday)		akoma Park If Under 24 Hrs.   8			Montgomery  9. Birthplace (State or Foreign		
	Director			1\\ M 2□ F	69 <sub>Yrs.</sub>	Months Days	Hours Min.	B. Date of Birth (Month, Day, July 27)	, 1939 Co	DC		
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	e Mar	ctor	Maryland Prince	George's		Chever1	У			1 X Yes 2 □ No		
	ath with th	al Dire	10e. Street and Number 1802 61st Ave	nue		10f. Zip Code 20	785	10	og. Citizen of What Co United			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madrial Evanther Trust be notified at once.	y Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	If Yes, Give	lo I	Vas Decedent of Hi fYes, specify Cuba I□Yes 2 XINo	ispanic Origin? (Spec n, Mexican, Puerto R Specify:	ity Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: A:			
5-0036	tol Ex	led b	15. Decedent's F	Year or Dates:	16a, Dece	dent's Usual Occup	ation	T 1	6b. Kind of Business	merican Industry		
21215	within 72 iene. • than "na	Completed by	(Specify only highest given the secondary (0-12)  12th	rade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired Receivin	furing most of working )	' T	Privat			
nd 2	be filed tal Hyg d other event, I	Be	17. Father's Name (First, Middle, Las			THE COLVERY	18. Mother's Name (					
Maryland	d Men marke	၉	John Mark H				Dilth					
	nd 2 sl alth an 27 is r ir traur		19a. Informant's Name/Relationship Michael C. Haizl			-	ourt Ft.		City or Town, State, .	20744		
Baltimore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 [		20b. Place of Dispo				Oc. Location - City or			
ţ	t. Pag rtment rtant: I		4 □ Donation 5 □ Other (Spec	ify)	Lee's Cre	matory	18, 2	009 C	linton, Ma	ryland		
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Lite	ensee Dow					neral Home ngton, DC			
	Physician		23a. Part 1. Fig. r the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	v one cause on each lin	Α			respiratory arre	st,	Approximate Interval Between Onset and Death		
P	/Medical Examiner		resulting in death)	Due to (or as	aconsequence of):  five Head  aconsequence off:  way Art	of Fuile	ine	100		2 mauter		
	pe sit	iner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (St as)	nonsequence of)	΄ λ-	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1		a learn		
^	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	eng 61	sease/			7 9		
760,				d			ı					
289	ertifica ing ph as th	Medi	IF FEMALE:									
O. Box	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	1	<u></u>	23d. Date of de Month	livery Day Year		
s, P.	res that signed to be deta	by PI	Part II. Other significant conditions	•	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	,		
ord	w require been si should b	ted	Hyperteurin	M	<del></del>			1 □ Ye	s 2 No 3 P	robably 4 Unknown		
I Records,	: The law cate has b	Completed						24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of		
Vital	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?	Hospital:		1011	26. Place of Death					
4	Phys er this eral dii	To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	nt 2 ER/Outpatien  y 28b. Time of		4 U Nursing Hom		nce 6 Other (Spe	ecify)		
ion	ending I sath. or: After he funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day on	(Year) Injury	Work	? Yes 2 □ No		,,			
Division	al or Atte s after de al Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre . <i>(Specify)</i>	eet, factory, office	28	Bf. Location (Str City or Town	reet and Number or R , State)	ural Route Number,		
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  Certifying P 2 Medical Example 1	Physician: To the best of aminer: On the basis of and manner sta	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)		
_	To th To th comp		29b. Signature and title of certifier	talla	400	29c. License		29	od. Date signed (Mon	th, Day, Year)		
			30. Name and address of person who	www	MD	5	2119		6/9/0	7		
R	10		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, I	Frint) Fange	2 Parlan	vers gr	4 /2 104: L	Treenhelt, MD		

State Registrar

-0000-	2 hours after death with the Maryland atural", or items 23a or 28a-f show acal Examiner must be notified at
Dalillore, Mai ylallu 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at
,	Physicia /Medica Examine
Division of Vital necolus, r.O. Dox 68769,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar  1. Decedent's Name	ne (First, Mida	tle, Last)				Cei	rtificat	e or L			2. Date of D		- Kunn	009	3. Time	of Death	
ın al	Helen L.	. Johns	on									Month 6		ay 1	Year 2009	1:2	3 p '	
er	4a. Facility Name	(If not institutio	on, give s	street and nu	ımber)			4b. City,	Town, or	Location	of Death		4	c. Count	y of Death			
	4924 Ser				T =			Beth		16 1 1 1 1 1 1 1 1 1	- 04 Hes	0.0.1.1.0		Conto	omer			
	5. Social Security		6. Sex	( ]M 2 <b>[</b> ★F	7. Age (In	n yrs. last l	birtnday) Yrs.	If Under Months	Days	Hours	r 24 Hrs. Min.	8. Date of B	ay, Yea		Cou	place (State Intry)	e o <i>r For</i> e	
	218-20-1 Usual Residence					82						4-16-	1927	/	TN			
	10a. State	10b. County	•			c. City, To		cation								10d. Inside	-	
cto	MD	Montg	omer	У	Be	ethes	sda							1  Yes 2				
Dire	10e. Street and No						10f. Zip Code							10g. Citizen of What Country?				
ral	4924 Ser	ntinel						208					USA			ican Indian,		
by Funeral Director	11. Marital Status 1 □ Never Mar 3 🌠 Widowed		rried	12. Was Ded Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 🔀 No live	r in U.S.	U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)  1 □ Yes 2 ☑ No Specify:						0-		ack, White	, etc.		
Completed	(Spe	15. Decede ecify only high condary (0-12)	est grade	e completed	) (1-4or 5+)	16	Sa. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa rk done o se retired	ation Juring mod	st of work	ing			Business/Ir			
S		12				<u>_</u>	xecu	tive	Assi			· · · · · · · · · · · · · · · · · · ·			cal W	ork		
Be	17. Father's Name											(First, Middl		en Surna	ime)			
၉	Frank L.			ne Print)		140	9h Maii:	na Addross	(Street			nighte al Route Num		or Tour	State 7	in Code)		
	Helene I			,	ter	- 1		•	,			, Beth						
1	20a. Method of Dis	sposition			2			osition (Nar				Date		·		Town, State		
	1 ☐ Burial 2	Cremation 5 Other (	3 □R Specify	emoval fron	i State	-		matory or d emat		1	6-12	-2009	Han	OTTOY	, MD			
1	21. Signature of	-//		ee,	M0141		2	2. Name ar	nd Addres	s of Facil	lityHar.	ry H. N ike, E	√itz	ke's	Fam			
	23a. Part 1. Enter	the disease, o	or compli	cations that	caused the	death. D										Approxin Interval E	nate	
1	Immediate Cause	eart failure. Lis e (Final	st offig of		rian (	Cance	r									Onset an	nd Death	
	disease or conditi resulting in death	)			(or as a co													
	Cognestially list o	anditiona	1															
iner	Sequentially list of any, leading to it cause. Enter Und	ierivina	Į	Due to	(or as a co	onsequenc	e of):											
Examiner	Cause (Disease or injuly that initiated events resulting in death) Last C. Due to (or as a consequence of):																	
calE	Due to (or as a consequence or):																	
by Physician/Med	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 months?	2		birth 2 inant at time	Fetal dea		⊒Ectopic p ⊒ Other <i>(sp</i>							ate of delive	very Day	Year	
Y P	Part II. Other sign	nificant condit	tions cor	ntributing to	death but no	ot resulting	j in the u	nderlying o	ause give	n in Part	1.	23e. Did	tobacc	o use coi	ntribute to	the cause of	of death?	
												1 🗆	] Yes	2 <b>⊠</b> No	3 ☐ Pro	obably 4	Unkno	
Completed												per	opsy formed:	?	prior to c death?	topsy finding completion o	gs availa	
Be	25. Was case refe	erred to medic	al							26. Plac	ce of Deat	1□ Yes h <i>(Check only</i>			, D 162	-∟ INU		
일	examiner? 1 ☐ Yes 2 <b>½</b>	No	F	lospital: 1	] Inpatient	2 🗆 ER/0	Outpatie	nt 3 DC	Othe	er: 4□ N	lursing Ho	me 5 <b>X</b> Re	sidence	6 □0	ther (Spec	cify)		
e G	27. Manner of Dea 1 Natural	ath 5 ∐ Pendi	ing		of Injury nth, Day Ye		. Time o Injury		8c. Injury Work	:?		28d. Describe	how in	jury occi	urred			
÷ l	2 Accident 3 Suicide 4 Homicide	invest	tigation	28e. Plac	e of injury - ding, etc. (S	At home, Specify)	farm, str	M reet, factor		Yes 2□	]No	28f. Location City or T	(Street own, Sta	and Num ate)	nber or Ru	ral Route N	lumber,	
ertifica																	se(s)	
edical Certification:	(Check only	2∐ Medica		29b. Signature and title of certifier  29c. License number  29d. Date signed (A											Day Voo			
edical	(Check only one)			1/4	Inne	ela										i, Day, Teai	7	
edical	(Check only one)  29b. Signature an	d title of certifi	n who co	ompleted cau	use of death	(Item 23a	a) (Type,	Print)	3599	6			6-	11-2		i, Day, Teal		

			for State Registra AMEND#7 perFH6/	State of Ma 12/09,BMW,Mo	-	-	artmen tificate			and Me		jiene	) fi fi ()	206	15
	Physicia	an	Decedent's Name (First, Middle, La     Marvin	st) Katz							2. Date of Dea Month June 4	Day	, 009 Yea	3. Time of 11:55	
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location o	of Death		4c.	County of De		
#			Gladys Spellman					ever		24 Hrs.	8. Date of Birth			eorge's	or Foreign
П	Funeral Director		5. Social Security Number 6. 5 577-22-2829	Man 2□F	-71	st birthday) 12 Yrs.	Months	Days	Hours	Min.	May 23,	19:	37 Mai	cyland	n r orongiv
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				<u> </u>			10d. Inside C	ity Limits
	Maryla	to		George's	Che	verly								¥□Yes	2 🗆 No
	vith the	Funeral Director	10e. Street and Number 2900 Mercy Lane		,		10f. Zip		785			-	.S.A.	Country?	
	ms 23s	eral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Dece			gin? (Spe	offy Yes or No- Rican, etc.)		14. Race - Ar	nerican Indian,	
936	urs after of, or Ite	by	1 ☐xNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:			r ves, spek 1 ☐ Yes		Specify:		rican, etc./		Black, Wi	White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any figury or other traumatic event, Ite Medical Examinar must be notified at ance.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)		kind of wo DO NOT u	al Occupa rk done d se retired	ation during most	t of workin	g .		ind of Busines		
21	led wit lygiene her the	Соп	17. Father's Name (First, Middle, Lasi	4		Sal	es	1	18 Mothe	r'e Namo	(First, Middle,		an Brol	ker	
Maryland	uld be fi Mental H irked ot itic ever	To Be	Paul Katz	,					A	nne l	Kier				
Mary	d 2 sho		19a. Informant's Name/Relationship Robert A. Gazzol								Route Numbe			, Zip Code)	
re,	of Heal	1	20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Na	ne of	ce)	D	ate	20c. L	ocation - City	or Town, State	
Baltimore,	: Page tment c tent: If tent: If		1 ☐ Burial 2 ☑Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	Met	ropol:				-	10,09			ia, Va.	
Ba	Depar Depar Impor any In		21. Signature of Funds (Service Lice	XIII	0131	2.	222 W	isco	nsin	Ave.		Wasl		n, D.C.	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each l	d the death. ine.	. Do not en	ter the mod	de of dyin	ig, such as	cardiac o	r respiratory ar	rest,		Approxima Interval Be nset and	tween
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequ	ence of):								Das	1>
	Examiner	-	Sequentially list conditions,	b. Due to (or as	a consequ	ence of:									
	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
3760,	ficate be executed physicien and is the burial-transit	cal Ex	resulting in death) Last	Due to (or as	a consequ	ence of):									
99	artificate ing phy e as the		IF FEMALE:											J	
.O. Box	that the death certificat led by the attending phy detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[	⊒Ectopic p ⊒ Other (s <sub>i</sub>		/				23d. Date of Month	Day	Year
S, D	Se jo	ρ	Part II. Other significant conditions	Contributing to death	out not resu	Iting in the L	J-C	cause giv	en in Part I	l. 		obacco Yes 2		e to the cause of Probably 4	death? JUnknown
Record	s t	Completed	ENcepha	lopat	hy	4	VOX	C			24a. Was	osy	prior	autopsy findings	available cause of
	Page Page		Respiration	1 failu	ie v	leviti	late	* D	eper	iden	1 ☐ Yes	2 No	death		
Vital	S 0 0	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆 I	ER/Outpatie	nt 3□ D	OA Oth	100		ne 5⊟Resid		6 ☐Other (S	ipecify)	
on of	ding Physia.	lon: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Di	ury ay Year)	28b. Time o Injury	of M	28c. Injur Wor	ryat rk?  Yes 2 □	1	28d. Describe	how inju	iry occurred		
Division	l or Attending after death. Director: After I in by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place of In	jury - At ho tc. (Specify	me, farm, st			1103 2.		28f. Location (3 City or Tox			r Rural Route Nu	mber,
	Hospitel 4 hours Funeral aly filled	edical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	of examinat	wledge, dea ion and/or ir	th occurred vestigation	at the tin	me, date ar opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s date an	s) and manne ad place, and	r as stated. due to the cause	(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	- 0		, (			se number					onth, Day, Year)	
	ł		Strull	mell	cre	and		10	183	52		Ju	INE S	200	9
			30. Name and address of person who	completed cause of	death (Item	23a) (Type	Print)	NS	bores	120	Hya	th	sike k	11/20	120
9	Sta Regist		31. Date filed (Month, Day, Year)	nng / Regis	trar's Signal	1. Lo	wed	5							

# Maryland 21215-0036 Baltimore,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 200 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2009 **Physician** June 5:30 A M MARY ELIZABETH KEENEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glade Valley Nursing & Rehab. Ctr. Frederick Walkersville 9. Birthplace (State or Foreign Country) 1919 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Days Months Hours 1 □ M 2√2 F 212-24-5071 Sept. 11, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experient must be notified at 10a. State 10b. County 1 Tyes 2 No Funeral Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 100 Burgess Hill Way #317 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Exercitivations. 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: ģ Widowed 4 ☐ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar M. Summers Mattie Baugher ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11202 Cranford Drive, Upper Marlboro, MD 20772 Carol A. Richardson / Daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rocky Hill Cemetery 6/12/09 Woodsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 Loka de of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or comshock, or heart failure. List only or complications that caused the Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (onas a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or es a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 □Yes 2 ☑No the 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗆 No 1 □Yes 2 XNo Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this al or Attending Physical States death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide n 24 hours aft ie Funeral Di the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa UNE who completed cause of death (Item 23a) (Type, Print 5

State Registrar

DHMH 17 Rev 1/2001

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12 2009

(Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day Year **Physician** Dorothy Ann Kolsch June 08 2009 7:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 612 Jupiter Hills Court Anne Arundel Arnold 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 70 123-30-2456 Director Nov. 20,1938 New York Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shov event, the Medical Exa⊤riner must be notflied at Anne Arundel Arnold Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 612 Jupiter Hills Court 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🔀 Married 9 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ş White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mailroom Supervisor Bank is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Clarence Owen Thorpe Dorothy May Latourette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Kolsch / Husband 612 Jupiter Hills Court Arnold, MD 21012 27 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 June 15 2009 1 X Burial 2 ☐ Cremation 3 X Removal from State Farmingdale, New York Pinelawn Memorial Park 4 Donation 5 Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a rt1. Inter the disease, r c shock, or heart failure. V st implications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate ause (Final disease r condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, I admy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending phi for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> Be Completed 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □Yes 1 ☐ Yes 2 □ No 2 / No director 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: filled in by the Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 300 ate Rd Hamis 31. Date filed (Month, Day, Year) State JUN 11

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate o	f Death		. F	leg. No.	20	09 2061
Physicia edical Examin	n/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year								3. Time of Death 1654 hrs
Culcai LXaiiiii	16.	4a. Facility Name (if not institution		1	4b. City, Town, or	Location of De	June 13,		ounty of Deat	
		7309 Gambler Drive			Upper Marlt			1	nce Georg	
Funeral		,	6. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Yea			rth(MM/DD		rthplace (State or
Director		219-27-2223	<sup>1</sup> X <sup>M</sup> <sup>2</sup> F 19	Yr	Months Days	s Hours	Min. 03/1	5/19	90 c	Washington DC
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	tion					10d. Inside City Limits
<b>*</b>		MD Princ	e Georges Upp	oer Ma	rlboro					1 Yes 2 X No
tarylar 28a-f	Director	10e. Street and Number	<u> </u>		10f. Zip Code				n of What Cou	intry?
vith the Maryland s 23a or 28a-f show s e notified at once.		7309 Gambier	Drive		2077	/2		USA		
ath wit tens 2 st be n	uneral	11. Marital Status  1 X Never Married 2 Ma	12. Was Decedent Ever in U.s		as Decedent of His Yes, specify Cuban		(Specify Yes or N erto Rican, etc.)	0- 14	1. Race - Ame White, etc.	rican Indian, Black,
ter des	4		1 Yes 2 X No	1	Yes 2 y No	specify:		Sc	oecify:Bla	ck
ours af atural camin	g b		or Dates: ify only highest grade completed)		nt's Usual Occupat	tion (Give kind			d of Business	
6 n 72 h nan "n ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	3	nost of working life	. DO NOT use	retired)		colleg	· e
5-0036 iled within 72 Hygiene. I other than	E	17. Father's Name (First, Middle,	l act)	Stud		18 Mother's N	ame (First, Middle,			
21215 uld be filed Mental Hy marked of	Bec	Andre' Lorr	,				la Coat		arriarrie/	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ည	19a. Informant's Name/Relationsh		51		et and Number	or Rural Route Nu	mber, City		20772
두 말씀 트뤼		Andre & Ange 20a. Method of Disposition	la Lucas/	7309	Gambie Sition (Name of cer		ve Uppe		rlbor	
of E			3 Removal from State	crematory or o	ther place)				•	
Baltim permit. Pag Department Important: injury or o	+	4 Donation 5 Other Sp. 21/Signature of Funeral Ceruse 1	cony.		ction Ce		5/19/09	CLi	inton,	MD
Balti permit. Departur Imports injury o		Jusa (1)	2MALA 1178			,	al Chap	$_{\rm el}$	20 H	St. NE
Physician		23a. Part L Enter the disease, or callure. List only one cause of	complications had caused the death. on each line. Complicat	Do not enter	the mode of dying, f methyle	, such as cardi enetetr	ac or respiratory at	rest, shock <b>Late</b>	, or heart	Approximate interval Between Onset and
/Medical xaminer	İ	Immediate Cause (Final disease or condition resulting in death)	a reductase mut	ation	140					Death
		Sequentially list conditions,	Due to (or as a consequence of b	).						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	F):						
ıi ii	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):						4
xecuted n and - transit		XUNPENDED	d	TT 27 .		POF 0/1	/00 mm			
ficate be ex g physician	/Medical	IF FEMALE:	AMENDED 23a, P		permE, g8	393 9/1	./09 11	724	Data of delive	
5876 ortifica ling ph		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 F	etal death 3	Ectopic pre	egnancy		Date of delive nonth	Day Year
Box 687 e death certifi the attending ed for use as t	Physicia	1 Yes 2 No 9 Unk	Pregnant at time of dea	ath 5 C	ther (Specify)					
O. B. int the d d by the etached		Part II. Other significant condition	ons contributing to death but not re	esulting in the	underlying cause (	given in Part I.	23e. Did	tobacco us	e contribute t	o the cause of death?
ires that signed	g p	Sickle cell	trait; obesity				1 Y	es 2	No 3 Pro	obably 4 🗸 Unknown
Sords law requir	plete						24a. Wa	psy	prior to	autopsy findings available completion of cause of
cal Records, ian: The law require certificate has been si	Completed							ormed?	death?	
ician: The certificate rector, page	Be (	25. Was case referred to medical examiner?	[Hospital: 4   Investigat 2			of Death (Ch				
of Ving Phys	£	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of		ry at Work?	ursing Home 5		ce 6 🗸 Oth	er: Scene
ion c tending eath. Ior: Af the fun	틸	1 X Natural 5 Pendi			1	Yes 2 No				
Division of Vital tall or Attending Physician: rs after death.  al Director: After this certilled in by the funeral director	Certification:		tigation 28e. Place of Injury - At ho	ome, farm, stre	eet, factory, office t	building, etc.	28f. Location or Town,		Number or F	Rural Route Number, City
Divisospital or / hours after meral Dire	S	4 Homicide determined	mined (Specify)				Or Town,	Otate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi	Medical	(Check only   Certifying Ph	ysician: To the best of my knowledg niner:On the basis of examination ar							
S i i i	Mec	29b. Signature and title of certifier	and manner stated.	1 /	29c. Licens	se number		29d. Da	ate signed (M	fonth, Day, Year)
		/4/11/1	11/1/1	/ (	,- O.C.	M.E.		June	14, 2009	
2			who completed cause of death (Item		Ct : 5 ::		04004			
G St	ate		Assistant Medical Examiner  82. Registrar's Signatu		nn Street, Balt	urnore, MD	21201			
Regist	rar	31. Date filed (Month, Day, Year)		far						
	004	1111 4 4 66	1.6							t has

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5 Day 200 9ear JUNE 22:10 P M **Physician** ARTHUR LOUALLEN Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 F If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 251-50-1939 73 Director SOUTH CAROLINA 12-20-1935 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Extending Industrial Longitised as once. T☐Yes 2☐No Director WASHINGTON DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1301 UPSHUR STREET N.W. #410 U.S.A. 20011 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK ĕ À 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LAUNDROMAT PORTER/ATTENDANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILLER LOUALLEN BONNIE WALTER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1301 UPSHUR STREET N.W. #410 WASHINGTON, DC 20011 MARILYN LOUALLEN/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
FT.LINCOLN 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Gremation 3 Removal from State 06-20-2009 BRENTWOOD, MARYLAND 4 Donation 5 Other (Specify 22. Name and Address of Facility JOHN. T. RHINES FUNERAL HOME LLC 3005 12th STREET N.E. WASHINGTON, DC 20017 Signature Juneral Service L Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final **Physician** disease or condition resulting in death) MONGUEY /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the sid be detached for 1 ☐ Yes 2 ☐ No 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending 24 hours after death. e Funeral Director: After 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal

within 2

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician:

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUN 1 1 2009

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

GREENBELT MARTLAND 20170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:45 A M Martinez 2009 Mary June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 617 Pin Oak Road Severna Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex **Funeral** Hours Days 1 □ M 2 🔀 F Months 80 June 10,1928 West Virginia 214-52-9265 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Exprinent intal be netified at once. 10a. State 10h County MD Anne Arundel Severna Park 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21146 USA 617 Pin Oak Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify. Specify: White <u>چ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 8 filed w Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Huzey Anna Kosut Mike ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Severna Park, MD 21146 Horace P. Martinez / Husband 617 Pin Oak Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 08 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 Metro Crematory, INC. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** stat disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed ttending physician and or use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 T Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 D No 2 X No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2. ₹No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

completely State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Registrar

(Check only

31. Date filed (Month, Day,

29b. Signature and title of certifier

Year)

and manner stated.

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 29d. Date signed (Month, Day, Year)

Please Type or Frint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar			Certif	ficate of L	Death		Reg. No.	2005	20021
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-	Examin		4a. Vacility Name (If not institution, giv			46		Location of Dea	ath	4c.	County of Death	
			Hanbon Huse 16.5		(In yrs. last birtl	heby) If	Under 1 Year	If Under 24 Hr	s. 8. Date of I	3irth	9. Birthr	place (State or Foreign
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	Director		Usual Residence of Decedent						prarcii			
	yland	.	10a. State 10b. County		10c. City, Town	or Locati	ion				1	0d. Inside City Limits 1 X Yes 2 □ No
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	ath w		2401 Dumfri			1		230–300			United S	
	items	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No		13. Was	s Decedent of H es, specify Cuba	ispanic Origin? ( ın, Mexican, Pue	erto Rican, etc.)	NO-	Black, White,	
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-	Physician	6 17	shock or heart failure. List only Immediate Cause (Final	one cause on each line	an Olad	1.1	Care ti				1	Onset and Death
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of o	Physician: this certifica at director, p	2	1 Yes 2 100	Hospital: 1 ☐ Inpatier	nt 2. ER/Ou	tpatient Time of	3 LI DOA				6 ☐ Other (Spec ury occurred	oify)
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of	of my knowledge	e, death o	occurred at the t	ime, date and pl	lace, and due to	the cause	(s) and manner as	s stated.
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2	4	-	Name and address of person who	1 +-		(Type, Pri	int)		0 0	11:	ne MD	21215
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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 5, LILLY McCARTHY 2009 2354 C. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHEVERLY PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ XF Yrs Director 88 MAY 8, 219-54-6249 1921 JAMAICA Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director PRINCE GEORGES UPPER MARLBORO 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code items 23a or 2 iner must be no 10204 PRINCE PLACE, Funeral #T-5 20774 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or item Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: BLACK <u>۾</u> "natural", 3 Widowed 4 Divorced er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. snt: If item 27 is marked other than Lry or other traumatic event, It's M 12th NURSE AIDE SIBLEY HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVTD ALEXANDER **McCARTHY** LOLA CLAREDETH ROBINSON ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL MULLINGS - SON 1019 HEATHER AVE., TAKOMA PARK, MARYLAND 20912 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or FT. LINCOLN CEMETERY: 06-11-2009 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Si mature of Fureral Service Licensee 22. Name and Address of Facility RONALD TAYLOR II FUNERAL HOME John Williams 10583 MIDDLEPORT LANE, WHITE PLAINS, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULM NARY DISESE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed and burial-tran Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) o. 9 Unknown 9 Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2

No 24a Wasan certificate has 2 **X**No 1 □Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🕍 No 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA in by the funeral dir Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 113 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated To the within 2 29d. Date signed (Moghh, Day, Year) 29b. Signaty 29c. License number 30. Name the address of person who completed cause of death (Item 23a) (Type, Print) 1221 MERCANTILE LN, UPPER MARLBORO, ANITA K. CLAYTON, MD MD 20774 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Rose Maree McNair 1330 M 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ladys Spellaran Spe Chever 6 euros If Under 1 Year | If Under 24 hirs 9. Birthplace State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. ast birthday) **Funeral** 1 M 2 X F Months Days Hours Min. 579-42-1679 Director 31, 1930 Georgia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location s 23a or 28a-f show 1 XYes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. United States 20019 4933 Minnesota Ave. NE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ∐Yes 2 🕱 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 XNo Specify: African If Yes, Give Year or Dates: Completed by 3 X Widowed 4 □ Divorced American "natural" er than "natur ; the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than 'r traumatic event, the way Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Sanders Rawleigh Sapp ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Richard S. McNair, Jr./ Son 12322 Quarterback Court Mitchellville Md. 20720 20c. Location - City or Town, State 20a Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 17, 2009 | Brentwood, Maryland 4 Donation 5 ☐ Other (Specify) Lincoln Cemetery of Fundral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig 20019 Washington, DC 4001 Benning Rd. NE Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ntraeran disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner notor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred She will deliver of ear new funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural driver Travelling fast. 1 ☐ Yes 2 ☐ No 2ctober 6, 2007 s after death.

I Director: A
id in by the fu 2 Accident 6729M t. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö STICET Full prove, Wishing Far Furthern Lacetifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. College of the cause (s) and manner as stated. To the Hospital within 24 hours a To the Funeral I 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 0/627329d. Date signed (Month, Day, Year)

State

JUN 1 5 2009 Registrar

31. Date filed (Month, Day, Year)

Murthy Revathy, 3001 Hospital Drive Cheverly, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Alan Nelson

Please Type or Print in Black Indelible Ink. Ensure All C	opies Are Legible.		
State of Maryland / Department of Health and Ment	al Hygiene	2009	2062
Certificate of Death	Reg. No.		
s Name (First, Middle,Last)	2. Date of Death	3. Time o	

	1- For State Certificate of Death Reg. No.									<u>)</u>				
Physician	Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month D								Day	Year	1	me of Death 618 hrs		
edical Examine	er.	Jonathan Alan							June 17,		County of			-
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		28 Hump Road				If Under 1 Year		24Hrs	8 Date of B	Birth (MM/D	D/YYYY	9. Birthplac	e (State or	┥
Funeral	5	Social Security Number 6. Sec		In yrs. last birth		Months Days		Min.				Foreign		
Director		366-74-5491 1X	M 2 F	5	9 Yrs.				Jan.21	1, 19	50		lichigan	-
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death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	0e. Street and Number				21740			ļ	USA				
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ith wi	Funeral	Marital Status     Never Married 2 Married	Armed Forces?	-	If Y	es, specify Cubar	n, Mexican,	Puerto F	Rican, etc.)	Ì	White	etc.		
er dea			1 Yes 2 If Yes, Give Year	X No	1	Yes 2 X No	specify:				Specify:	White		_
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be netified at once	a⊢	15. Decedent's Education (Specify or	or Dates:	oleted) 16a. I	Deceden	t's Usual Occupa	tion (Give k	ind of wo	ork done	16b. K	(ind of Bus	siness/Indus	try	
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more, MD 2121 Pages 1 and 2 should be frent of Health and Mental nnt: If item 27 is marked	ŀ	Philip M. Nelson,	Brother	20b. Place	of Dispos	sition (Name of ce		DIC	Date	20c.	Location -	City or Tow	n, State	$\neg$
of Be	- 1	1 XXBurial 2 Cremation 3	Removal from Sta	te cremat	tory or ot	her place)	Ì	06/	10/200	) LI	rford	lsburg	ΡΔ	
Page Page ment tant:		4 Donation 5 Other Specify	:	Betne		mmunity Name and Addres	ss of Facility						, , 111	ᅱ
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Lice	nsee	MO14/9		ove Fune	eral F	ome Jome	.P.A.H	Hanco	ck,MI	2175	0-0368	
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COF e law 1 e 2 sh	Completed by									performed Yes 2	? No	death? 1 ✓ Yes	2 No	
Division of Vital Records, rat or Attending Physician: The law requir rs after death an Inserted at the rate of th		25. Was case referred to medical				26.Pla	ace of Deat	h (Check	only one)					
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Visior or Attencather death Director:	fica	2 Accident Investig 3 Suicide 6 X Could n	28e Place of I	niury - At home	farm, st	reet, factory, office of resi	de building,	etc.	28f. Loca or To	ition (Stree own, State)	et and Nun ) <b>28 H</b>	ump Re	al Route Number, C ${f d}$	City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		(Ondok only	ician: To the best of r	ny knowledge, o	death oc	curred at the time	e, date and	place, ar occurred	nd due to the Lat the time,	e cause(s) , date and	and manr place, and	d due to the	cause(s)	
Fo the vithin compl	Medical		and manner stated	I.			ense numb			29	d. Date si	gned (Mon	th, Day, Year)	
	Ž	29b. Signature and title of certifier	11 10				C.M.E.			J	une 17,	2009		
		Mh Dra	onely IIN	<u>}_</u>	- >									
OCME		30. Name and address of person wh	o completed cause of Assistant Medica	death (Item 23) al Examiner	a) 111	Penn Stree	t, Baltimo	ore, MI	D 21201					
		Melissa Brassell, MD 31. Date filed (Month, Day, Year)		rar's Signature	4									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 10:35 P<sup>M</sup> June 11 2009 Charles Peach John /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs 1930 Maryland Jan 14, Director 217-24-7200 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Expring mast be notified at 1 ☐ Yes 2 X No Directo Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 USA 5427 Fallriver Row Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Lvs.
Armed Forces?
1 Myes 2 □ No
If Yes, Give
Year or Dates: 1951-54 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 □Yes 2X No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City College (1-4or 5+) Elementary/Secondary (0-12) Police Department 12 Captain 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lola Theresa Hart John Samuel Peach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5427 Fallriver Row Court Columbia, MD 21044 Beverly S. Peach/wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 06/13/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Goiling Holle Cremation Service P.O. Box 784 21. Signature of Funeral Service Licensee Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cheeses **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year for Month Day 5 Other (specify) ⊒Yes 2 □ No Ö 9 Unknown detached 9 Unknown ۵. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð sign I be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 2 🗆 No certificate 2 🗹 No 1 ☐ Yes 1 □Yes Division of Vital ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral L 1 **retifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 025205

(vot)

State Registrar 31. Date filed (Month

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N. Charles St. Beetts. Md 2020/

Name and address of person win completed cause of death (Item 23a) (Type, Print)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 20626

			1 - State Of Mar State Registrar	Cert	ificate of L	Death		eg. No.	20020			
F	Physicia	an	Decedent's Name (First, Middle, Last)     FRANCES MAE QUICKLEY				2. Date of Dea Month	Day Year	3. Time of Death			
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	9	4b. City, Town, or	Location of De	eath	4c. County of Death				
1	LAAIIIIII		CITIZENS NURSING		HOAU		¿ GRACE					
	Funeral Director			(In yrs. last birthday) 101 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	8. Date of Birth (Month, Day APR 15,	1908 MAF	nplace (State or Foreign untry) XYLAND			
	and ww		Usual Residence of Decedent           10a. State         10b. County         1	l 0c. City, Town or Loca	ation				10d. Inside City Limits			
	Many a-f sho ified a	tor	MARYLAND HARFORD			HAVRE I	DE GRACE		1 XYes 2 □ No			
	th with the 23a or 28a ist be not	al Directo	10e. Street and Number 415 S. MARKET STREET		10f. Zip Code	21078		10g. Citizen of What Co UNITED STA				
5-0036	be filed within 72 hours after death with the Maryland Ital Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes Z ☑ No If Yes, Give Year or Dates:		/as Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	spanic Origin? in, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK				
212-0	filed within 72 ho Hygiene. other than "natur ent, the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done on ONOT use retired	ation during most of )	working	16b. Kind of Business/	Industry  E HOMES			
2	filed w Hygier Ither th		9 17. Father's Name ( <i>First, Middle, Last</i> )		OPEDITE:	18. Mother's	Name (First, Middle,					
land		To Be	HARRISON WHYE			MATIL	DA SMITH					
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) SHIRLEY WATSON / DAUGHTER	_				er, City or Town, State, 2				
Baltimore,	9 0 <del>-</del> -		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem HARFORD ME	atory or other plac	· ;	Date 06/15/09	20c. Location - City or ABERDEEN	Town, State  MARYLAND			
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	T	Name and Addre	ידותנים ידי	RAL HOME, T. HAVRE I	P.A. E GRACE, M	D 21078			
9			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not ente	r the mode of dyir	g, such as car	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death			
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	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	consequence of):								
68760,	tificate be executed ig physician and as the burial-transit	edical E	d									
	ertifica ling ph		IF FEMALE: 23c. If yes, outcome pl	f pregnancy		15.00		23d. Date of de	livan			
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Fetal death 3 🗆	Ectopic pregnancy Other (specify)	/		Month Month	Day Year			
ds, P.	w requires that the d been signed by the should be detached	b	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contribute t Yes 2 √No 3 □ P	o the cause of death? robably 4 ☐Unknown			
SCOL	aw req	Completed	0				24a. Was		utopsy findings available completion of cause of			
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Vita	sician; certific	Be	25. Was case referred to medical examiner?  Hospital:	A CELEDIOUS STATE	Oth		Death (Check only o		if v)			
0	g Physicar this ieral direction	n: To	27. Manner of Death 28a. Date of Injury	t 2 ER/Outpatient  / 28b. Time of  / Year)	28c. Inju			dence 6 Other (Spendown injury occurred	эспу)			
sior	tendin eath. tor: Aff the fur	catio	2 Accident investigation		M 1 □	Yes 2 □ No		Otherstand Number of E	Rumi Pouto Number			
<u>X</u>	after d Direct in by	Certification:	4 Homicide determined 28e. Place of injur building, etc.	y - At home, farm, stre (Specify)	еет, тастогу, описе		City or To	Street and Number or F wn, State)	lurar noute Number,			
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner state and manner state.	examination and/or inv	occurred at the tivestigation, in my	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)			
	To the within To the comple	Me			29c. Licens	se number	_	29d. Date signed (Mon	nth, Day, Year)			
	4		1 Winam ~15	ر 	D_	326	09	6/10/09	•			
	2		30. Name and address of person who completed cause of dea Kamady Milhami M	ath (Item 23a) (Type I	erolutio	n St	Have.	e Goare M	021078			
12	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar	r's Signature	ales							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician**  $A^{M}$ Katherine Raspet 8:15 2009 June 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Skyway Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Hours Months Days 173-24-1049 1 □ M 2 2 2 1 93 Director Sept. 26, 1915 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show r than "natural", or items 23a or 28a-f shoi the Medical Exp. cher must be notified at 1 ☐ Yes & No Anne Arundel Annapolis Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 U.S.A. 1140 Mainsail Drive permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exercises and once. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married White 1 ☐Yes 2 ☑No Specify Specify 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Post Office Postal Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Laharner Martin Raspet ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1140 Mainsail Drive Annapolis, Maryland Joan Philpott/niece 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Twin Valley Mem. Park 6/11/2009 Delmont, Pennsylvania 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Junera Service Liceosee 147 Duke of Gloucester St., Annapolis, MD 21401 toda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cevebrovascular disease Immediate Cause (Final disease or condition resulting in death) OVVS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) the 9 Unknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 2 **2** No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ED

10

Bestgate Rd. Annapolis, Md. 21401

		•	1 - For State of Maryland / State of Maryland /	Department of H Certificate of I			ene 009	20628
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time ol Death
	Physicia /Medic		Eunice Ely Smith			June 1	10 2009	8:15 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number) 1384 Fairfield Loop Road	4b. City, Town, or Crownsvi	r Location of Death .11e		Anne Arui	nde1
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 91	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02/08/19		hplace (State or Foreign nintry) nnsylvania
	pu &		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tox	wn or Location				10d. Inside City Limits
	Aaryla r eho	ত	· ·	sville				1 ☐ Yes 2 <b>∑</b> No
	28a-	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	ountry?
	h with	ai D	1384 Fairfield Loop Road	21032		υ	ISA	
	deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
92	or it	by Fu	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖁 No	Specify:		Specify: W	hite
Ö	hours tural			a. Decedent's Usual Occup	pation	1	6b. Kind of Business	/industry
7	in 72 n "na ne lic	plet	(Specify only highest grade completed)	(Give kind of work done life. DO NOT use retired	during most of worki d)	ng		
212	d with piene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ T	Ceacher		P	ublic Sch	ools
ng n	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. le markad other than "natural", or iteme 23a or 28a-f show eumatic event, the McJical Exactinar must be notified at	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name		laiden Sumame)	
yla	ould to Ment Ment Merkac	P	George Kline Ely		Jenny Bo		O'the Terror Chair	Tin Code)
Maryland 21215-0036	alth and 2 sh			b. Mailing Address (Street 384 Fairfiel				
ore	ages 1 and of He		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	of Disposition (Name of ery, crematory or other place politan Crem	CB)		Oc. Location - City or Alexandri	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce.		4 Donation 5 Other (Specify)  21. Signature of Firster I Service Licensee # 992	22. Name and Addre Advent Fur Annapolis	on of English			
	205 = 9		23a. Part1. Enter the disease, or complications that caused the death. Do					Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition				si,	Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence			•		1
	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a ofj.				
8760,	ate be executed hysicien and the burial-transit	icai Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	a of):				
876	cate b physic the b	edica	d.					
D. Box 6	Attending Physician: The law requires that the death certificate be executed robath.  cloath.  actor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 9 □ Unknown	th 3 Dectopic pregnanc 5 Other (specify)	у		23d. Date of de Month	olivéry Day Year
P. 0.	that the ed by detach	/ Phy	Part II. Dther significant conditions contributing to death but not resulting	in the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	w requires been sign should be	ed by	atrial Fibrillation		<del></del>	1 □ Ye	s 2 No 3 F	robably 4 Hunknown
Division of Vital Records,	fhe law requ te has been age 2 shoult	Completed				24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
ital	ysician: The is certificate had director, page	4	25. Was case referred to medical		26. Place of Deat		7.10	
>	Physici this ce al direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Julpatient 3L DOA	her: 4 Nursing Ho	me 5 Reside	nce 6 Other (Sp	ecify)
0 00	ling Ph		1 ☐Natural 5 ☐ Pending (Month, Day Year)	Time of 28c. Inju Wo	ry at rk? Yes 2 No	28d. Describe ho	w injury occurred	
ivisio	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, building, etc. (Specify)			281. Location (Sti City or Town	reet and Number or F	Rural Route Number,
L	the Hospital thin 24 hours a the Funeral Empletely filled		29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination	ige, death occurred at the fi	ime, date and place, opinion, death occur	and due to the ca	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	thin 2 the I	Medical	one) and manner stated.  29b. Signature and title of certifier		se number		9d. Date signed (Mor	
	F 3 F 8		8 las Casa		15297		June il,	
_	>		30. Name and address of person who completed cause of death (Item 23a		) - ( [		200.10 1	
				binson Road,	Severna l	Park MD	21146	
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 12 2009  Linux 8.	parts.				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. (\_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** June 12 2009 1:38 P M Trapp Stokes Dorothy Louise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 4008 4th Street North Beach If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-18-1934 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral Days Min. Hours 1□M 2XF 578-46-4200 74 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It e Modical Examiner must be rediffed at once. 1 X Yes 2 ☐ No Director MD Calvert North Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20714 4008 4th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) collection agency 12 account receivable secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be G. Sr. Dorothy Louise William Trapp, ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5445 Bayview Avenue, St. Leonard, MD 20685 Kellie V. Little, granddaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 6/15/09 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final mall Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last execut and burial-tran Due to (or as a consequence of): Box 68760, physician pe Physician/Medical death certificate the use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 E 1 □ Yes Attending Physician: funeral director, 25. Was case referred to edical 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 nesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSP. R.D. Prince Fredorick, M.D. 20678 ANNAR MUNSHI. MD. 10 32. Registra s Signature 31. Date filed (Month, Day, Year) State JUN 1 5 2009▶ Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 5:42 AM 15, 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 132 South Vermont Street Williamsport If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 □ M 2X F 76 Feb. 12, 1933 Maryland 220-28-3472 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must by retified at 1X Yes 2 □ No Director Maryland Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 132 South Vermont Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: White Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Postmaster U.S. Postal Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Leroy Dorsey Florence May Moats ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George M. Stumbaugh - Husband 132 S. Vermont St. Williamsport, MD 21795 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 06-16-2009 Smithsburg, Maryland 4 Donation 5 ☐Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CCCinoma **Physician** 3 months /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ANo 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 2<del>/⊡No</del> Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director; Aft
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

WH-4

State

Registrar

Sanjay Saxena M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1138 Opal Court

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown, MD 21740

29c. License number

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eileen Stecker June 08 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar. 17,1922 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 214-12-2308 1 □ M 2 🗓 F 87 Director Maryland Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location or 28a-f show Examiner must be notified at MD Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 650 Americana Drive T2 21403 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black White etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ∐Yes 2 👿 No Specify. Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William D. McGinley, III Laura Mae Allan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any Injury or other trau Gale Stecker Soroka / Daughter 650 Americana Drive T2 Annapolis, MD 21403 20b. Place of Disposition (Name of Du Paniey created to other place) Memorial Gardens 20a. Method of Disposition June 12, 2009 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 5 ☐Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Signature of Funeral Service Licensee 7 rt1. Enter the disease, or c shock, a heart failure. List o Plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. mediate Cause (Final Physician ere grova scular accident disease of condition resulting in death) /Medical Due to (or as a consequence of) Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran this certific al director. ieral Director: A filled in by the fi

Box 68760.

P.O.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine yperten sion Due to (or as a consequence of). Coronan Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aspiration preumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 -N 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 Tho Other: 4 \( \sum \) Nursing Home 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06/08 2009 D60 390

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

11:20 A M

10d. Inside City Limits

White

1X Yes 2 □ No

within 24 hours a

To the Funeral E

completely filled

Registrar

MEDICAL

(ENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JABER

JUN 11 2009

31. Date filed (Month, Day,

ANNE ARUNDEL

Registrar's Signature

		-	State of Maryl  1 - State Registrar		rtment of Health		Hygiene	7 11 11 3	20632
			Registrar  1. Decedent's Name (First, Middle, Last)		imodio oi bodi	2. Date	of Death		3. Time of Death
4	Physicia	an	Florence Scarboroush			Mon	th Co Da	y 13 Year	0400 M
	/Medid Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	on of Death	40	. County of Death	
	CAMIIII	G1	Elkton Care & Reha	th d	EIKton			cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. Date rs Min. (Mor	of Birth hth, Day, Year,	9. Birth	place (State or Foreign ntry)
	Director		197-20-1610 10M 2007 8	Yrs.		12-	5-24	Per	insylvania
	and w	-	Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Lo	cation				IOd. Inside City Limits
	Aaryla sho	5	6 :1		Perryvi	ille			1X Yes 2 □ No
	ath with the Marylan s 23e or 28e-f show us the notified of	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	ntry?
	3e or		Concord Apartments, No. 403		21903	3		U.S.A.	
	after death w or Items 23e	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of Hispanic f Yes, specify Cuban, Mex	Origin? (Specify Yes	s or No-	14. Race - Ameri Black, White,	
9	after or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖔 No		1 ☐ Yes 2√∑ No Spec			Specify:	
93	within 72 hours after death with the Maryland jiene. r than "neturel", or Items 23e or 28e-f show tre Mazikai Evernituer aust ke netified at	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:				16b.1	V Kind of Business/Ir	/hite
15-	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during r DO NOT use retired)	most of working	100.1	Carlo of oddinodon	
12	within ene. than *	duc	Elementary/Secondary (0-12) College (1-4or 5+)  Eleven Years		Homemaker		P	ersonal F	Residence
2	Hyg the sht,	O)	17. Father's Name (First, Middle, Last)		18. M	lother's Name (First,	Middle, Maide	n Sumame)	
lan	o d at to	To B	Harry T. Bandy					. Eckman	
Maryland 21215-0036	and and Is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Nu			or Town, State, Zi	o Code)
Σ,	1 and 1 Health tem 27		Ann Gross		ee Lane, Ell	kton, Mary		21921 Location - City or T	own State
Baltimore,	00-	1 4	1   Hurial 2 V   Gramation 3   Hemovalitom State		sition (Name of matory or other place)	1	We	st Cheste	
Ë	tent: tent:	١,	'4 □ Donation 5 □ Other (Specify)	R.A. Ferr	is & Co., Inc	06/15/09		Pennsy	lvania
Ba	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licenses	30 L	.ee A. Pattei	rson & Son	Funer	al Home, 21903-070	P.A.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying, such				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	unlen	2 Cano	with	bi-	er	Oriset and Death
	/Medical Examiner		resulting in death)  Due to (or as a co	nsequence of):	0	L	rets.		
	Lxammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a c.	n suppose of).					
	ted nsit	nlne	Cause (Disease or injury	(					
,	be executed sician and burial-transit	Examlne	that initiated events c. resulting in death) Last Due to (or as a co	nsequence of):					
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Ical	d						
9	ntifica ng ph as th	Medi	IF FEMALE:			-			
Вох	eath certific attending p I for use as I	an/	23b. Was decedent pregnant  1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
O. E	the at	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	e of death 5	Other (specify)				
٥	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause given in F	Part I. 23	e. Did tobacco	use contribute to	the cause of death?
Records,	signe signe d be	d by					1 🗌 Yes	2 □ No 3 □ Pf	obably 4 □Unknown
COL	w requir been s	Completed				24	a. Was an	24b. Were au	topsy findings available
Re	icien: The lav certificate has ector, page 2	dmo				10	autopsy performed? Yes 2	death?	ompletion of cause of 2 No
Vital	en: T tificat tor, pa	Be C	25. Was case referred to medical		26. F	Place of Death (Chec	100		
<u>&gt;</u>	Physicien: this certificatal director, particular	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient	2 ER/Outpatie	nt 3□ DOA Other: 4.	Nursing Home 5	Residence	6 ☐Other (Spec	eify)
u of			27. Manner of Death 1X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Work?		escribe how in	jury occurred	
<u>S</u>	Attending at death. ector: After by the fune	catio	2 Accident investigation		M 1 ☐ Yes		tine (Stroot	and Number or Ru	mi Poute Number
Division	or Att	Certification;	4 Homicide		reet, factory, office	Z81. LO	ty or Town, Sta	ate)	rai Houle Number,
	pital ours a erel [		29a. Certifier X Certifying Physician: To the best of m	v knowledge, deal	th occurred at the time, da	te and place, and du	e to the cause	(s) and manner as	stated.
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical	(Check only 2 Medical Examiner: On the basis of examiner) and manner stated	amination and/or in	nvestigation, in my opinion	, death occurred at the	ne time, date a	and place, and due	to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. License num	nber		Date signed (Monta	
			> Arlander	) ,	D0026	183		6.13.0	7
•	1)		30. Name and address of person who completed cause of death						
	2		Madhu Sachdev., M.D., 322 Ea		Avenue, Nor	th East,	Marylar	nd 21901	
	St Regist	ate	JUN 15 2009 Server B.	Signature					
\$10	, riegist	. di	JUN - 0 2003 Chromes p.	yours					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Year) 1 M 2 □ F Months Hours 214-70-4318 53 Director January 28, Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Directo Maryland Anne Arundel Arnold 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 2 21012 955 Blue Fox Way USA Funeral items ? 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. The Manager and Once. 1 XYes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No <u>ک</u> Specify: White 3 Widowed 4 Divorced Year or Dates: 1974–1975 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WSSC Commercial Meter Reader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Burkley James L. Spicer, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 955 Blue Fox Way, Arnold, MD 21012 Sharon A. Spicer / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 6/16/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. tons Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NTESTINAL CANCER UNKNOWN ORIMAN 3 MONTHS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) o. cate has been signed by the page 2 should be detached Tyes 2 No 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □ No certificate 2 No 1 🗆 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No Inpatient 2 ER/Outpatient 3 DOA After this Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending after death. I Director: Af d in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number, City or Town, State) determined 4 ☐ Homicide filled 24 hours

State

within 2

5+1 31 29a. Certifier

(Check only one)

DHMH 17 Rev 1/2001

32. Re

FNSt

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28d. Date signed (Month, Day, Year)

William Snyder

09-04284 UNK UNK

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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NAIC OINC		1-For State Critificate of Death	-	- N-	
Physician		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Deat		3. Time of Death
শুবুical Examin		William Snyder	Month May 29, 20	Day Year 009	1520 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of D	
_		4619 Dallas Place Temple Hills		Prince Ged	
Funeral Director		5. Social Security Number 578-54-7839  1 X M 2 F 66 Yrs.   T. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Min    Usual Residence of Decedent		9/1942	Birthplace (State or Foreign Country)  Virginia
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	<u>_</u>	Maryland Prince George's Temple Hil	1s		1 X Yes 2 No
Aaryland 28a-f show	S L	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	Country?
3 or office	ਙੋ	4619 Dallas Drive 20874		United	States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 23s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No		- 14. Race - A White, e	American Indian, Black, etc.
after	<u>``</u>	3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	
hours Fram		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Busin	ess/Industry
36 uin 72 han dical	D D	Elementary/Secondary (0-12) College (1-4 or 5+)  12th  Mailer			
d with	Completed	1 Zth Mailer 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N		ivate
215 215 be file ntal H.	PR PR	unknown Ri	ta Mae S	Snyder	
MD 21215-0036 a 2 should be filed within 7 b and Mental Hygiene. a 77 is marked other than unatic event, the Medica		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or			
MC 2 sl alth ar auma		Dorothy M. Howard/ Sister 4718 Bass Place S.E.	. Washi	ngton, DO	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	une		
timent trant:	1		, 2009		, Maryland
Balt permit Depar Impor	4	2) Sponeture of Funeral Sorving Company (22) Name and Address of Facility Steel 4001 Benning Rd.	N.E. W	ashingtor	n, DC 20019
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arr	est, shock, or heart	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):			Death
The same of the sa	-	b			
	اخ	if any, leading to immediate Due to (or as a consequence of):			
	ᇍ	Colleges or injury that initiated expert resulting in death). Last the college of			
uted fd ransit		events resulting in death) Last  Due to (or as a consequence of):  d.			
7 <b>60,</b> cate be executed physician and he burial - transit	Medical Examine	UNPENDED AMENDED			
		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	í l
Sox 687 leath certific e attending for use as t	Ä	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year
Box 68 e death certification the attending ed for use as	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
that the d		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ite to the cause of death?
Division of Vital Records, P.O. rate of Attending Physician: The law requires that it is after death.  The Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2.	ğ S	· · · · · · · · · · · · · · · · · · ·	1 Yes	s 2 No 3	Probably 4 Unknown
Vital Records ysician: The law requi	Completed		24a. Was autop	osy prio	ere autopsy findings available or to completion of cause of
Reco	티		perfo 1 <b>Y</b> es		ath? ✓ Yes 2 No
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical 26. Place of Death (Check examiner?			
hysic al dire	인	1 Yes 2 No Thospital 1 Inpatient 2 ER/Outpatient 3 DOA Outer4 Nursi		Residence 6	
n of ding Pl		27, Manner of Death  28a, Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?  1 ✓ Natural 5 ─ Pending	28d. Describe	how injury occurred	'
Sio Atten r death ector: by the	<u> </u>	2 Accident Investigation 28e Place of Injury - At home form street factory office building etc.	28f Location (	Street and Number	or Rural Route Number, City
Divi	Certification:	Suicide Could not be determined (Specify)	or Town, S		or real real real real real real real rea
ig par i		29a. Certifier 1 Cartifidas Physicians To the best of my knowledge, death accurred at the time date and place and	d due to the caus	se(s) and manner a	s stated.
thin 2 the I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
F W F S	<del>§</del>	29b. Signature and title of certifier 29c. License number	-	29d. Date signed	(Month, Day, Year)
		Caral Halan O.C.M.E.		May 30, 200	9
CRI	f	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
Sta	te.				
Registr		31. Date filed (Month, Day Year)  32. Registraris Signature  34. Aparticular description of the control of the			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 2009 **Physician** 5:30 p M STMMS JERMAINE Μ. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 1 x 1 M 2 □ F 1972 Washington, DC 218-15-7067 15 Director 36 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No CAPITOL HEIGHTS Director PRINCE GEORGES MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 USA 464 POSSUM CT. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. an "natural", or iten 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 9 3 ☐ Widowed 4 ☐ Divorced BT.ACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4or 5+) APTA ADMINISTRATIVE ASSISTANT 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PATRICIA SIMMS ပ GARY OFFUTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3362 CURTIS DR. #302 SUITLAND, MD. 20746 PATRICIA A. SIMMS-MOTHER item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ŧ Department of Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK 6-11-2009 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MD MARSHALL S FUNERAL HOME OF MARYLAND 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACQUIRED IMMUNODEFICIENCY DISEASE YRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WKS RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed DAYS Exami SEVERE METABOLIC ACIDOSIS burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical DAYS HYPOVOLEMIC SHOCK the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be o \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier parich, BM MD -4-2009 D0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1500 Forest Glenn Rd. Silver Spring, MD. 20910 Barbara Supanich,

DHMH 17 Rev 1/2001

State Registrar Randy Lee Shoemaker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		l-For State Registrar		C	Certifica	te of i	Death				F	Reg. No	).		
Physicia		Decedent's Name (First, Middl	Name (First, Middle,Last) 2. Date of Death 3.						3. Time of Death						
edical Examii		Randy Lee Sh	oemaker								Month June 14,	2009	Year		0816 hrs
		4a. Facility Name (if not institutio		ımber)		4t	. City, Town	or Lo	cation of				c. County of	Death	
		13806 Old Orchard R	idge Road				Hancock						Washing	ton	
Funeral	-	5. Social Security Number	6. Sex	7. Age (In yr	rs. last birth	iday)	If Under 1	/еаг	If Under	24Hrs.	8. Date of E	irth (MN	A/DD/YYYY)	g. Birtl	hplace (State or
Director			.VV	,		12 Yrs.	Months [	ays	Hours	Min.	-	20.	1000	Foreigr	n untry) MD
		219-68-0333	1XXM 2 F			+∠ Yrs.					June	<u> 29,</u>	1966		***** MD
<u>*</u> -	}	Usual Residence of Decedent  10a. State 10b. County		100.0	City, Town o	or Locatio	n								10d. Inside City Limits
w any							11								1 Yes 2 XXNo
Aaryland 28a-f show 1 at once.	ö	MD Washi	ngton	На	ancock	ζ									
Mary 28a-	Director	10e. Street and Number					10f. Zip Cod	е				10g. Ci	itizen of Wha	at Coun	itry?
1 the Maryland 3a or 28a-f sho		13806 Old Orch	ard Ridge	Road		i	2175	0					USA		
with ns 23	Funeral	11. Marital Status		cedent Ever i	n U.S.		Decedent of					10-			can Indian, Black,
Jeath r iten	<u> </u>	1 X Never Married 2 M	arried Armed F	orces?	lo.	If Ye	s, specify Cu	ban, N	Mexican, I	Puerto Ri	can, etc.)		White	, etc.	
fter o		3 Widowed 4 Div	orced If Yes, Give Ye			1	Yes 2X	No :	specify:				Specify:	W	hite
5-0036 led within 72 hours after dygiene. other than "natural",	함	15. Decedent's Education (Spe	cify only highest gra	de completed			s Usual Occi					16b	. Kind of Bus	siness/Ir	ndustry
72 hc	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	<b>-</b>   •	luring mo	st of working	lite. D	10 NOT u	ise retire	<b>d</b> )				
136 thin thin than than	힏	11			F	Loor	Tech					H	ome Co	nst	ruction
S-O	Ö	17. Father's Name (First, Middle	, Last)					18	. Mother's	Name (f	irst, Middle	, Maide	en Sumame)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Roy Sherwood	Shoemaker						Vale	ria	R. Yo	unke	er		
21 Ould b	2	19a. Informant's Name/Relations	ship (Type, Print)		19b	. Mailing	Address (S	treet a	and Numb	er or Ru	ral Route N	umber,	City or Town	n, State	, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Valeria R.Shoe	maker/Mot	her	13	3806	01d 0:	rch	ard	Ridg	e Roa	d Ha	ancock	,MD	21750
and and lealth	1	20a. Method of Disposition					tion (Name o	f ceme	etery,	_	Date	200	c. Location -	City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	- 1	1 Burial 2 X Cremation	n 3 Removal f	rom State		ory or oth				06/1	7/200	۔ ا			MD
timen trant		4 Donation 5 Other S			smiths		Crem								
Salt ermit epar mpon njury		21. Signature of Funeral Service	Licensee				ame and Add								
	4	Je Jee	- 1 DOVI	S N	101419										750-0368
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the de	eath. Do no	t enter th	e mode of dy	ıng, sı	ucn as ca	irdiac or i	espiratory a	arrest, s	snock, or nea	art	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease	a Diabe	tic ke	toaci	dosi	S								Death
<b>X</b> ammer		or condition resulting in death)	Due to (or as	a consequen	ce of):										
	L	Sequentially list conditions,	b					_							
	<u>ē</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequen	ce of):										
	amine	(Disease or injury that initialed	Due to (or as	a consequen	ice of):						_				-
ted d ansit	Ä	events resulting in death) Last	ч .												
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	/Medical	XUNPENDED	AMENDED	23a,P	II,27	,per	ME, g8	93	7/20	0/09	TT				
8760, ificate be ug physic is the buri	₩ E	IF FEMALE:	23c. If yes	outcome of	pregnancy							7	23d. Date of	deliver	у
687 ertific	an/	23b. Was decedent pregnant in t past 12 months?		birth		Fet	al death	3	Ectopic	pregnan	су		Month	ı	Day Year
Box 68 e death certif the attending	: <u>:</u>	1 Yes 2 No 9 Un	transmit =	nant at time	of death 5	Oth	ner (Specify)					- 1			
he de	Physician		9 Unki	nown		- f <b>ab</b>	- 4 - 4 - 5		in De	a 1	220 Di	d tobac	co use contr	ibute to	the cause of death?
ires that the signed by	by F	Part II. Other significant condi	•		`	_		-							bably 4 Unknown
ires i	ğ	Hypertensive	e atheros	crerot	ic ca	rato	vascul	.ar	aise	<u>eas</u> e				-	
rd.	Completed										24a. W	as an topsy			utopsy findings available completion of cause of
e law te has ge 2 sl	Ē											rformed s 2		death? ✓ Y	'es 2 No
tal Rec		25. Was case referred to medical	al	•			26.5	Place o	of Death (	Check o		3 2	140	•	2 10
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use an	æ	examiner?	Hospital:	Inpatient 2	2 EP/O	utpatient		- 1-	Other		Home 5	Res	idence 6	✓ Othe	er: Scene
f Vi Physical this	욘	1 ✓ Yes 2 No 27. Manner of Death		e of Injury		Time of Ir			at Work				injury occur		
n of ding Ph After t funeral	Certification:	1 V Natural	(Mon	th, Day,Year)	1200	11110 01 11			es 2				,,		
Sior Attend r death ector: by the	ati		estigation									(0)			Carl Davida Number City
Vision A after Dire	ij		ild not be	ce of Injury -	At home, fa	arm, stree	et, factory, of	ice bu	ııldıng, et	c.   '	28f. Locatio or Towi			er or R	tural Route Number, City
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Ç	4 Homicide	ermined (Specif)	<i>'</i> )											
To the Hos within 24 h To the Fur		29a. Certifier 1 Certifying F	hysician: To the be	est of my kno	wledge, dea	ath occur	red at the tim	e, dat	e and pla	ice, and	due to the c	ause(s)	and manne	r as sta	ited.
oth ompl	Medical	one) 2 Medical Exa	aminer: On the basis and manner	s of examinat stated.	ion and/or i	nvestigat	ion, in my op	inion,	death oc	curred at	the time, da				
- > - >	ž	29b. Signature and title of certifi	er				29c. Li	cense	number			29	d. Date sign	ied (Mo	onth, Day, Year)
		Dam ).	IM				C	C.N	1.E.			J	une 16, 2	2009	
		30. Name and address of perso		use of death	(Item 23a)										
		Donna M. Vincenti, M				111	Penn Str	eet,	Baltimo	ore, MI	21201				
9	tate			Registrar's Si	gnature								-		
Regis		IIIII O C	0000		6	1									
DHMH 17 Rev 1/2 OCME 2006	001	30N 2 0	OCME	in	A. OF	IGINA	L								

DHMH 17 Rev 1/2001 OCME 2006

		For State of Maryland	I / Department of Health a Certificate of Death		Reg. No.	2063
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Michael Lawrence Tappan		2. Date of De Month <b>June</b> 8	ath Day Year 3, 2009	3. Time of Death
Exami Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  16216 Monty Court  5. Social Security Number  089-32-1473  6. Sex 12 M 2 F 68	4b. City, Town, or Location of Rockville  St birthday) If Under 1 Year If Under 1  Months Days Hours	24 Hrs. 8 Date of Bir	ay, Year) Co	
ס		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location kville			10d. Inside City Limits 1 ☐ Yes 2X No
with the 3a or 28a	al Directo	10e. Street and Number 16216 Monty Court	10f. Zip Code 20853		10g. Citizen of What Co USA	untry?
und 21215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene.  d other than "natural", or items 23a or 28a-f show event, its Modrel Examiner must to recitied a	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Ye ar or Dates: 1960	If Yes, specify Cuban, Mexican	gin? (Specify Yes or No i, Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh:	e, etc.
21215-0036 d within 72 hours aft giene. er than "natural", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)  Insurance Agent	t of working	16b. Kind of Business/ Insurance	
aryland 212: should be filed within and Mental Hygiene. s marked other than umatic event, ILEM	To Be Co	17. Father's Name (First, Middle, Last) Phillip Ritchie Tappan		or's Name (First, Middle thy Decker	, Maiden Surname)	
re, Marylars s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Mary R. Tappan/Wife	19b. Mailing Address (Street and Number 16216 Monty Cour	er or Rural Route Numb t, Rockvil	per, City or Town, State, 2 le, MD 2085	Zip Code) 3
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once.			of Heaven Cemetery  27 Name of Address of Columbia  Of University	2009 Tins Funer	al Home Inc	ing,Maryland
Medical be executed Wedical Examiner by physician and true burial-transit to burial-transit	edical Examiner	23a. Part 1. Steer the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Line funderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) of the conditions of the co	CANCET  and CANCET  ence of):	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death Lyears 2 years
Box ( ath certi attending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
rds, P.O. I	by	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I		tobacco use contribute to	
VITAI HECOTGS, sician: The law requires t certificate has been signe irector, page 2 should be o	e Completed	25. Was case referred to medical	26 Place		opsy prior to formed? death? 2.₩No 1 □Yes	utopsy findings available completion of cause of s 2 □No
FION OF ending Phy ath. or: After this ne funeral d	Certification: To Bo	examiner?  1 Yes 2 No  1 Inpatient 2 If  1 Inpatient 2 If  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation	ER/Outpatient 3 DOA Other: 4 Nt 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2	28d. Describe No 28f. Location	idence 6 Other (Spe how injury occurred	
Hospita 4 hours Funeral tely filled		29a. Certifier  (Check only  2 Medical Examiner: On the basis of examinat				
To the To the To the To the Complet	Medical	29b. Signature and title of certifier  Famual  And manner stated.	29c. License number	20	29d. Date signed ( <i>Mon</i>	th, Day, Year)
St	ate	30. Name and address of person who completed cause of death (Item <b>Sarrett Keily</b> 31. Date filed (Month, Day, Year)	D 3919 2331 (Type, Pringlandwood) 23418 (Clandwood)	1 Ct., #1	11, Olney,	MD 20837

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 20638. 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ **Medical Examiner** June 10, 2009 1919 hrs Lamar Delonte Thomas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park | Months | Days | Hours | Min. | Min. | Min. | Min. | Min. | 10-8-1993 | Birthplace (State or Foreign Washington Country) | DC | Country | DC 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director  $_{1}X_{M}$ 2 F Yrs 10-8-1993 <u>577-25-6</u>799 15 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Y Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho
injury or other transmitie event, the Medical Examiner must be notified at once. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 6th Street, SW 20024 USA 喜 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2X No Yes 4 Divorced If Yes, Give Yea 1 Yes 2 X No specify: Black Specify ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked None 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Larry Clark Barbara Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mable Bowler/Guardian 400 6th Street, SW, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Fort Lincoln Cemetery 6-23-2009 Brentwood, MD 4 Donation 5 Other Specify. 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Aspiration of gastric contents Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi. The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f,perME, g893 //6/09 TT X UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy for use as Month Day Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions o contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | δ Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No certificate 1 🗸 Yes Hospital or Attending Physician: 24 hours after death 25 Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🖊 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification within 24 hours after death

To the Funeral Director: A
completely filled in by the fu 1 Natural prox. Aspiration after vomiting 1 Yes 2 X No Pending 6/10/09 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9630 Milestone Way College Park, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be single family home determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 16, 2009 30. Name and ordress of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

State Registrar

**OCME** 

		For State Registrar	e of Maryland	Certifica				eg. No. 🤈 [	nna	2063
		Decedent's Name (First, Middle, Last)					2. Date of Deat Month		Year	3. Time of Death
Physic /Medi		CLARA TH	HARRINGTON				MAY		0 <sup>8</sup> ar	6:01 Р м
Exami		4a. Facility Name (If not institution, give street and	d number)			cation of Death	4c. County of Death PRINCE GEORGE'S			
/		7706 MERRICK LANE			ANDOVE	R f Under 24 Hrs.	O Data of Birth			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs. Month		Hours Min.	8. Date of Birth (Month, Day			place (State or Foreign htry)
Director		578-26-2142 Usual Residence of Decedent	90				JUNE 2	2 1910	NOR.	TH CAROLIN
/land low		10a. State 10b. County	10c. City,	Town or Location					1	10d. Inside City Limits
Mar.	tor	MD PRINCE GEORGE	E'S LAY	NDOVER						1∏Yes 2∏No
or 28	Director	10e. Street and Number		10f.	Zip Code		1	Og. Citizen of	What Cour	ntry?
th wi	la [	7706 MERRICK LANE			20785			USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evertiest must be realled at any injury or other traumatic event, the Modical Evertiest must be realled at once.	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. ed Forces? ∕es 2 Moo s, Give or Dates:			eanic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
2 hor	Completed	15. Decedent's Education (Specify only highest grade comple		16a. Decedent's U	sual Occupation	on ring most of worki	na	16b. Kind of E	Business/In	ndustry
thin 7	nple		ge (1-4or 5+)	life. DO NO	use retired)			PRIVA	ΔΤΕ	
ed wi ygier <b>ver th</b>		7TH		DOMES		8. Mother's Name	(First Middle			
the file antal H ed oth	Be	17. Father's Name (First, Middle, Last) GREEN PERSON			1	B. Mothers Name ANNIE	HOLDEN		ine)	
nd 2 should Ith and Me 27 is mark traumatio	2	19a. Informant's Name/Relationship (Type. Print, ELAINE THARRINGTON/DA		19b. Mailing Addr 7706 MER	ess (Street an RRICK L	d Number or Rura ANE LAND	al Route Numbe OVER, MA	r, City or Town RYLAND	n, State, Zij 207	p Code) 85
Pages 1 and 2 ment of Health a ant: If item 27 is ury or other trai		20a. Method of Disposition  1 \$\sqrt{3}\$ Burial 2 □ Cremation 3 □ Removal 1  4 □ Donation 5 □ Other (Specify)	cer	nce of Disposition (in metery, crematory of DAR HILL	or other place)	!	Date 2009 S	20c. Location	-	
permit. Departm Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility J. B. JENKINS FT 7474 LANDOVER ROAD LANDOVER, MAI								
Physician / Medical Examiner buhasician and physician and the prival transit t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CARDIAC A ue to (or as a conseque CONGESTIV ue to (or as a conseque HYPERTENS ue to (or as a conseque	ence of):  E HEART I  TICE of):  IVE CARD	FAILURE		EASE			
death certifi e attending id for use as	Physician/Medical	in the past 12 months?	s, outcome of pregnan Live birth 2 ☐ Fetal of Pregnant at time of de Unknown	death 3 Ectop	ic pregnancy (specify)				Date of deli	very Day Year
ires that signed t	ğ	Part II. Other significant conditions contributing	to death but not result	ting in the underlyin	ig cause given	in Part I.				the cause of death?
: The law requires that the cate has been signed by th page 2 should be detache	Completed	25. Was case referred to medical				26. Place of Deat	1 □Yes	rmed? 2 TNo	prior to c death?	topsy findings availat completion of cause o
# # 15	o Be	examiner?  1 Yes 2 XNo  Hospital:	1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	Other		ome 5 ဩ Resi		Other (Spec	cify)
ysiclan: The s certificate director, pag	n: T	27. Manner of Death 28a.	Date of Injury	28b. Time of	28c. Injury Work?		28d. Describe			
Phys r this ral dir	100	1 Matural 5 Pending 2 Accident investigation	(Month, Day, Year) Place of Injury - At hon	Injury M me, farm, street, fac	1 □ Ye	es 2 No	28f. Location (: City or Tov	Street and Nut	m <i>ber</i> o <i>r Ru</i>	ıral Route Number,
ding Phys n. After this funeral dir	ificatio	3 Suicide 6 Could not be determined 28e.		/				, 5.0.0)		
or Attending Phys frer death. Director: After this in by the funeral dir	Sertificatio	4 ☐ Homicide determined 20e.	building, etc. (Specify)							
or Attending Physiter death.  Director: After this in by the funeral dir	edical Certification: To	4 Homicide determined 206.  29a. Certifier (Check only 2 Medical Examiner: On	To the best of my know	vledge, death occu ion and/or investiga	rred at the time tion, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as e, and due	s stated. to the cause(s)
or Attending Phys frer death. Director: After this in by the funeral dir	Medical Certificatio	4 Homicide determined 206.  29a. Certifier (Check only 2 Medical Examiner: On	To the best of my know the basis of examinati	vledge, death occu ion and/or investiga	rred at the time tion, in my op	inion, death occu	, and due to the rred at the time,	29d. Date sig	ned (Month	h, Day, Year)
the Hospital or Attending Phys hin 24 hours after death. the Funeral Director: After this mpletely filled in by the funeral dir		4 Homicide determined 206.  29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: On and	To the best of my know the basis of examinati	wledge, death occu ion and/or investiga	ition, in my op	number	, and due to the rred at the time,	29d. Date sig	e, and due	h, Day, Year)
or Attending Physiter death.  Director: After this in by the funeral dir		4 Homicide determined 206.  29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and 29b. Signature and title of certifier	To the best of my know the basis of examinatid manner stated.	ion and/or investiga	29c. License	number	, and due to the rred at the time,	29d. Date sig	ned (Month	h, Day, Year)
or Attending Phys ifter death. Virector: After this in by the funeral dir		4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed	To the best of my know the basis of examinatid manner stated.	23a) (Type, Print)	29c. License	number	rred at the time,	29d. Date sig	ned (Month	h, Day, Year)

				State of Mar em 3,23a,25	yland/Depa per me ge Cei	strong of 23 tificate of	lealth and I 709dhb Death			9 20640
3	Physic /Medi Examír	cal	Decedent's Name (First, Middle, I)  JOHN  4a. Facility Name (If not institution, g)	PATRICK	T.	EAGUE 4b. City, Town, c	or Location of Death	2. Date of De Month June	Day Ye 200 4c. County of D	9 unknown M
	Funeral Director		216-72-8689		In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	hite Ha	8. Date of Bir (Month, Da		timore  Birthplace (State or Foreign Country)  Maryland
	death with the Maryland ms 23a or 28a-f ehow freunt be notified at	Director	10e. Street and Number	imore	Oc. City, Town or Lo	10f. Zip Code	White Ha	all	10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 1 No Country?
903	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, it is Marical Expunsion must be notified at once.	by Funeral Director	2304 Meredi  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve	11		1161 Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	- 14. Race - A	States merican Indian. //hite, etc. White
d 21215-0036	filed within 72 he Hygiene. ther then "naturint, it a Masical	Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 11. Father's Name (First, Middle, La.	College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired Machi	during most of work d) nist			ss/Industry
Maryland	and 2 should be latth and Mental I	To Be	Robert  19a. Informant's Name/Relationship Sharon Teague	Lee (Type, Print)			May	Est		Holmes e. Zip Code) 21161 Maryland
Baltimore,	permit. Pages 1 a Department of Hea Important: If Item eny injury or othe once.		20a. Method of Disposition  1 Burial 2 Coremation 3  4 Donation 5 Other (Spec	□Removal from State	20b. Place of Dispose cemetery, crem	sition (Name of natory or other place	on 6/1:	Date 1/2009	20c. Location - City Hampste	or Town, State
	eded in the eded of the eded o		23a. Part 1. Enter the disease, or conshock, or heart failure. List ont Immediate Cause (Final disease or condition	y one cause on each line.	H	ome, P.	A. Ja:	rretts	ville. M	n Funeral aryland Approximate Interval Between Onset and Death
	death certificate be executed  Be eltending physicien and office as the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Probab1 Due to (or as a complete or com	e Acute Monsequence of):	yocardia	1 Infarct	ion (NED BY N	EDICAL EXAMINER	
P.O. Box 6	et the death certifica by the ettending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	]Fetal death 3 □I	Ectopic pregnancy Other (specify)	V		23d. Date of o	delivery Day Year
	requires trees to been signe should be contact to the contact to t	6	Part II. Other significant conditions	contributing to death but n	ot resulting in the un	derlying cause give	en in Part I.	1 🗆 Y	′es 2 □ No 3 □	to the cause of death?  Probably 4 Munknown
ř,	an: The tifficete h	Be Completed	25. Was case referred to medical examiner?				26. Place of Deatl	1 ☐ Yes	2 No 1 □ Y	autopsy findings available o completion of cause of ? es 2 \sum No
5	al #	ertification: To	1 X Yes 2 + + + + + + + + + + + + + + + + + +			28c. Injury Work	4 🗆 Nursing no		lence 6 □Other (S	pacify)
NIC .	5 9 9	edical Certif	4 ☐ Homicide determined	28e. Place of triury building, etc. (5  nysician: To the best of miner: On the basis of exa	V knowledge death	gaguerad at the tim		City or Tow		
}	within 2	2	29b. Signature and title of certifier	HV-D		29c. License	number		29d. Date signed (Mo	nth. Day, Year)
	Stat		30. Name and address of person who David J. Hartig. • 31. Date filed (Month, Day, Year)	completed cause of death 1.D. 10155 Yo  /32. Registrar's	RK RD. STE	rint)	CKEYSVILL	E, MD 2	-1030	
h	Registra		JUN 2 3 2009			and the same of th				

partment of Health and Mental Hygiene

		-	For State Registrar	ryland / Depa <i>Cel</i>	rtificate of D			g. No. 2 1 1 Q	2064
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last)  LEONARD T. WITCZAK				2. Date of Death Month June	Day 2009	3. Time of Death 4:55 A.M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospi	tal	4b. City, Town, or L Rockvill			4c. County of Death	
grand.	Funeral Director		·	(In yrs. last birthday) 90 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 18		nplace (State or Foreign
	0		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			ι .	10d. Inside City Limits 11☑Yes 2☐No
:	e Mar 3a-fsh	Director	MD Montgomery	Gaithers			10	og. Citizen of What Cou	
:	3a or 28		10e. Street and Number 333 Russell Ave. #607		10f. Zip Code 2087	77	1	United Stat	
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 ※ Yes 2 □ N If Yes, Give Ye ar or Dates:	0	Was Decedent of His If Yes, specify Cuban 1 □Yes 2 ▼ No	panic Origin? (Spe , Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	in 72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupat e kind of work done du DO NOT use retired)	ion iring most of working		6b. Kind of Business/l	ndustry
717	d with giene. r thar	mo	Elementary/Secondary (0-12) College (1-4or 5-	Milit	ary Liason			NASA	
and,	d be filed ental Hyg ed othe s event,	Be	17. Father's Name (First, Middle, Last)  Louis Witczak			18. Mother's Name Mary Bla			
N.	should and Me mark umatic	으	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street ar	nd Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)
Ĭ.	and 2 salth a salth a r 27 is		Judy King (Daughter)					e, MD 2088	
altimore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropol	osition (Name of ematory or other place itan Crem.	200	9 <sup>10</sup> ,	Alexandria	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	MO1116 1		er Park I	r. Gait	hersburg,	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not er	nter the mode of dying	, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		requiting in dooth)	pulmonary	Arrest				
and a	/Medical Examiner	П	Pneumo						
	7 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
	ecuted and transi	Examiner	that initiated events	a consequence of):					
68760,	icate be executed physician and the burial-transit	edical E	d						
× 68	ertifica ding ph	Medi	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of de	alivery
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
S, P.	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause give	n in Part I.		bacco use contribute t es 2☑No 3□ P	o the cause of death?  Probably 4 Unknown
ord	requir been s hould	eted					24a. Was a	24h Were a	utopsy findings available
Rec	he law e has l ige 2 s	Completed					autops	sy prior to death?	completion of cause of
ţa	ian: T rtificat tor, pa	Be C	25. Was case referred to medical			26. Place of Deat			
<u>+</u>	hysic his ce I direc			ent 2 ER/Outpati		4 LI Nursing no		ence 6 Other (Sp	ecify)
o uc	ding P	ion	27. Manner of Death 28a. Date of Inju 1 Natural 5 Pending (Month, Da 2 Accident investigation		/ Work	/at :? Yes 2 ∐No	28d. Describe n	ow injury occurred	
Division of Vital Records,	or Attendate death Director:	Certification: To	3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm, s c. (Specify)			28f. Location (S City or Tow	itreet and Number or F rn, State)	Rural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical Ce	29a. Certifier 1 Certifying Physician: To the best (Check only one) and manner st	of examination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occu	, and due to the tred at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (Mor	
	15+1		Direction they m. i	)	Do	065509		June 10,	2009
	•			1 Medical	Center Dr	. Rockvi	ille, MD	20850	
į	St Regist	ate rar	31. Date filed (Month, Day, Year) 32 Regist.	rar's Signature	arked.				

			State of Maryland / Department of Health and 1- State Amend #18, 6-18-09, per FHDR, Health and 1- State Amend #18, 6-18-09, per FHDR, Health and 1- State of Death	d Men	_	0	000	20642
			1. Decedent's Name (First, Middle, Last)	2. [	Date of Death	J. No. 🛴	000	3. Time of Death
	Physicia			1	Vionth	Day 2	Year 200°)	A M
	/Medic Examin		Edna J. Wilson  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		une		nty of Death	0404 711
	LXdIIIII	eı	Saint Agnes Hospital Bultimere				,	
Т	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If	Hrs. 8. [	Date of Birth Month, Day,	Van ri		place (State or Foreign
	Director		104-14-3065 1 M 2 F 92 Yrs. Months Days Hours M	viin.   12	2-30-19	16	NY	intry)
	pu ,		Usual Residence of Decedent					101 1-11 01 11-11
	aryla shov	_	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits _ 1 ☐ Yes 2X No
	Ba-f	Director	MD Baltimore Catonsville		T			
	with the		10e. Street and Number 10f. Zip Code				of What Cou	ntry?
	sath is 23	eral	707 Maiden Choice In. #7205 21228	2 (Chaoifu)		ISA 14.5	Page Amer	inon Indian
	d within 72 hours after death with the Maryland giene. Ir than "natural", or items 23a or 28a-f show Ite Medical Examinar must to positive at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1. □ Yes 2 □ No	uerto Rica	n, etc.)		Race - Amer Black, White,	
5-0036	Ir, or	by	If Yes, Give 1 □ Yes 2 No Specify:  3 ☑ Widowed 4 □ Divorced Year or Dates:			Spe	ecify: TATE	ite
Š	2 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	-	16	6b. Kind of	f Business/li	
212	filed within 72 Hygiene. other than "nai	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of white DO NOT use retired)	working	1			
7	d wit	οū	12 Homemaker		С	wn Ho	ome	
g	be filed Ital Hy id othe event,	Be (	17. Father's Name (First, Middle, Last)  18. Mother's N	Name (Fir	st, Middle, Ma	aiden Surr	name)	
Maryland		인	William Isbister Margare	et Ic	bister	∸ Mar	garet	Garriock
a	2 sho		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or	r Rural Ro	ute Number, (	City or To	wn, State, Z	p Code)
	173票日		Patricia A. Hatch / Daughter 9690 Basket Ring Rd.					
0	Pages 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20	oc. Locatio	on - City or T	own, State
Ξ	. Pag tmen tant: jury		4 Donation 5 Other (Specify) Ardent Cremation 6-1	12-20			er, M	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Puneral Se, not Licensee M01411 22. Name and Address of FacilityHa					
_	G □ ₹ € Ø		fruit 4112 Old Columbia				City,	
			23a. Part tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart faflure. List only one cause on each line.	rdiac or res	piratory arres	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Sephic Shock					clays
	/Medical Examiner		Due to (or as a consequence of):					,
		-	Sequentially list conditions, b. Prevmonic of vncker photo	gy			-	weeks
	nsit	m j	cause. Enter Underlying Cause (Disease or injury	,				
	executed n and ial-transit	Examiner	that initiated events ' c					
8/60,	ficate be executed physician and s the burial-transit	dical	d.					
ĝ	tifical ng phy as th				W .			
ğ	death certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d.	Date of deli	very .
ם כ	law requires that the death as been signed by the atter 2 should be detached for u	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				Month	Day Year
	w requires that the de s been signed by the s should be detached	Å.	9 Unknown					
<u>ທ</u> ົ	es th	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					the cause of death?
cords,	een s	ted	Congestive heart failure	- L	1 ∐ Yes	2 [4] No	o 3∐ Pro	bably 4 Unknown
ပ္	law has b	Completed	Chronic Kidney disease	_	24a. Was an autopsy		prior to c	opsy findings available ompletion of cause of
<u> </u>	cate h	S	,		performe 1⊡Yes 2√l	od? SNo	death? 1 □ Yes	2 ANo
N I I a		Be	25. Was case referred to medical examiner? 26. Place of D	Death (Ch	eck only one)			
0	Phys this aldir	۲.			5 Residen			ify)
_	ding Fune	io	1 Natural 5 Pending (Month, Day, Year) Injury Work?	280.	Describe how	injury occ	currea	
VISION	death death ctor: y the	icat	3 Suicide 6 Could not be 280 Place of Injury. At home form street, festers office	28f I	ocation (Stro	of and Nu	mbor or Pu	al Route Number,
<u> </u>	affer Direction by	Certification:	4 Homicide determined building, etc. (Specify)	201. (	City or Town,	State)	illiber or Hai	ar noute rumber,
	spita lours lours reral		29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	place, and	due to the car	use(s) and	d manner as	stated.
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	occurred at	the time, dat	e and plac	ce, and due	to the cause(s)
	To th Comp	M	29b. Signature and title of certifier 29c. License number		290	d. Date sig	ned (Month	, Day, Year)
			Molammed ND MPH FACE DO064762		_	June	2,200	9
li	a	f	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				- 201	- 1
5	102		Narreesa Mohammed 900 S. Coilon Ave, Boilhimone	MP.	21220			
	Stat Registra	e	Nareesa Mohammed 900 S. Co. Lon Ave, Bollhing, a 131. Date filed (Month, Day, Year)  JUN 15 2009 Senera B. parks					
		1	JUNI D COUD LENGTH JO. Japanes					

ter Wilkinson	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death							
Physici	ian/	1. Decedent's Name (First, Middle,Last)	Death	Reg 2. Date of Death	No. 3. Time of Death			
edical Exam		PETER JOHN WILKINSON		June 9, 200	Day Year 19 1143 hrs			
9-		4a. Facility Name (if not institution, give street and number) Patapsco State Park	4b. City, Town, or Location of Catonsville	Death	4c. County of Death Baltimore County			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign			
Director	ĺ	551-77-0812 <sub>1</sub> M <sub>2</sub> F 49 <sub>Yr</sub>	Months Days Hours	Min. Jan. 29	O 1960 United Kingdom			
iny		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits			
ind show :	_		okeville		1 Yes 2 No			
Maryla - 28a-f dato	Director	10e. Street and Number	10f. Zip Code 2083		. Citizen of What Country?			
ith the 23a or notifie	a Di	13 Gregg Court  11. Marital Status			Great Britain			
leath w r items	Funeral	1 Never Married 2 X Married Armed Forces?	as Decedent of Hispanic Origir res, specify Cuban, Mexican, F		14. Race - American Indian, Black, White, etc.			
after d ral", or	by Fi	3 Widowed 4 Divorced If Yes, Give Year	Yes 2 No specify:		White Specify:			
2 hours "natur	ted		nt's Usual Occupation (Give kinnst of working life. DO NOT us		6b. Kind of Business/Industry			
036 ithin 7; ne. r than	Completed		acksmith		Metal Work			
15-0 filed w Hygie d othe	CO	17. Father's Name (First, Middle, Last) Ian Wilkinson		Name (First, Middle, Ma				
212' ald be: Mental marke:	o Be				er, City or Town, State, Zip Code)			
MD d 2 sho tth and n 27 is	-		Gregg Court,					
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiene 72 is marked other than "natural", or itens 23a or 28a-f show any injury or other traunatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Dispo	sition (Name of cemetery, her place)		20c. Location - City or Town, State			
timent rtant:		4 Donation 5 Other Specify: Metrpoli			Alexandria, Virginia			
Bal permi Depa Impo injur		( ) of ( ( + ) ) = 0 0 470	Name and Address of Facility Muriel H. Barb	er Funeral	Home			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	P.O. Box 503 he mode of dying, such as can	8, Laytonsy diac or respiratory arres	t, shock, or heart Approximate Interval			
/Medical Examiner		Immediate Cause (Final disease a. Multiple Injuries			Between Onset and Death			
M		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.						
	iner	if any, leading to immediate Due to (or as a consequence of):						
d sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical E	d. UNPENDED AMENDED						
'60, rate be exe physician ne burial -		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery			
Box 6876; death certificate the attending phy	hysician/N	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic p	regnancy	Month Day Year			
Box e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown	her (Specify)					
ires that the digner by the detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part		acco use contribute to the cause of death?			
ords, w requires s been sig	eted			24a. Was an	2 ✓ No 3 Probably 4 Unknown  24b. Were autopsy findings available			
Records, The law require	Completed			autopsy perform	prior to completion of cause of death?			
tal Rec cian: The certificate ector, page	a)	25. Was case referred to medical	26.Place of Death (C	1 Yes 2 heck only one)	No 1 ✓ Yes 2 No			
F Vita Physici r this c	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other		esidence 6 Other: Scene			
Division of Vital ral or Attending Physician: rs after death.  al Director: After this certicled in by the funeral director		27. Manner of Death       28a. Date of Injury       28b. Time of Injury         1 Natural       5 Pending       Jun 9, Year)       1127 hrs	njury 28c. Injury at Work?  1 Yes 2 ✔ N	28d. Describe how Subject jumpe	w injury occurred ed from bridge			
Vision or Attence free death or death or death in by the	ficat	2 Accident Investigation 3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre			eet and Number or Rural Route Number, City			
Division spiral or Attenchours after death uneral Director:	Certification:	4 Homicide determined (Specify) Bridge			te) Park, Catonsville, MD			
	g	29a. Certifier (Check only one) 1	red at the time, date and place	e, and due to the cause(s	s) and manner as stated.			
To the within To the comple	Medi	and manner stated.  29b. Signature and title of certifier	29c. License number		d place, and due to the cause(s)  29d. Date signed (Month, Day, Year)			
30		Who Browll Mid	O.C.M.E.		June 10, 2009			
OCM VE	Ε	30. Name and address of person who completed cause of death (Item 23a)						
			enn Street, Baltimore,	MD 21201				
St Regis	tate trar	31. Date filed (Month, Day, Year) 32/Registrar's Signature	Lad					

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State Of State Of State Of State Of State Registrar		rtificate of Death	R	eg. No. 2 1 1 9	20611
	1. Decedent's Name (First, Middle, Last)  hysician  (Modical  Howard Eugene Watson Jr				2. Date of Deat Month <b>June</b>	Day Ye ar <b>06 2009</b>	3. Time of Death 9:01 P M
/Medic Examin		a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dec  Southern Maryland Hospital  Clinton			th	4c. County of Death Prince Georges	
Funeral Director	Be Completed by Funeral Director	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		Year) 9. Birthp	lace (State or Foreign
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and any injury or other traumatic event, the Madfall Event and the Attending Event and Attending E		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Prince Georges Temple Hills			10d. Inside City Limits 1X Yes 2 □ No		
		10e. Street and Number  3206 Curtis Drive, #800		10f. Zip Code 20748	1	0g. Citizen of What Cour	try?
		11. Marital Status  1	<b>X</b> <sup>N</sup> °	Was Decedent of Hispanic Orlgin? ( If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 XNo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, of SpecifyBlack	etc.
		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) <b>aled</b>	orking	16b. Kind of Business/Ind	dustry
		77. Tarret o Harris (7 not) mestel Lasty			me (First, Middle, Maiden Surname)		
	၉	Howard Eugene Watson Sr. Etta Gr  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or R			ay ural Route Number, City or Town, State, Zip Code)		
		Wilhemina H. Miller/ Sist	2015 20b. Place of Dispo	37th St, SE #101 sition (Name of natory or other place)			)
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)  21 Signature Funeral Service License	Lincoln M	Mem Cemetery 6.1 2. Name and Address of Facility Donald Taylor II E			)
	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):					
		in the past 12 months?	23c. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day Year	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌riknow		
		Hypertensini Cardiovaicular Disease			- autop perfo	24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
	Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  28a. Date of Injury (Month, Day, Year)  (Month, Day, Year)  28b. Time of Injury M 1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	Certification: To						
tal or Atters after de al Directo	Certific						
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		29b. Signature and title of certifier		29c. License number 25		29d. Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )	
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Talme BoTello MD - 1328 Southern Ave 5E - DC 200					
Sta		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signatur	1			

			Plea	ise Type or Pri	nt in Bl	ack In	delible	nk. Ens	sure Al	l Copie:	s Are	Legible.	
			For State	State of M	laryland					lental H	ygiene		
			Registrar			Cei	rtificate	of Deat	h —		Reg. No.	2009	20645
	Physic	ian	1. Decedent's Name (First, Middle George Wi		rdler					2. Date of D June	eath Day 21	Year	3. Time of Death
A. P.	/Medi Exami		4a. Facility Name (If not institution				4h City To	wn, or Locatio			_	2009 County of Dea	11:20A M
J.	Exami	lei	709 E. Main St		/			Thurmor			4C.	Frede	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las	t birthday)	If Under 1		er 24 Hrs.	8. Date of B	irth		thplace (State or Foreign
	Director		147-20-6016 Usual Residence of Decedent	<b>1X</b> M 2 □ F	101	Yrs.	WOTHERS	ays Hours		Aug. 1	6, 19		ermany
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	a-fsh	ctor	Maryland Fre	ederick			Thu	mont					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citi	zen of What Co	ountry?
	s 23a		709 E. Mai					2178	-			J.S.A.	
<b>'</b>	fter de	Funeral	11. Marital Status 1 □ Never Married 2 □ Marr	12. Was Decedent Armed Forces? ried 1 □Yes 2 🔀	?	13. \	Vas Deceden f Yes, specify	t of Hispanic ( Cuban, Mexic	Origin? (Spe an, Puerto I	cify Yes or N Rican, etc.)	0-	<ol> <li>Race - Ame Black, White</li> </ol>	
036	al", or	by	3 vidowed 4 □ Divorced	If Vos Give		1	□Yes 2₺	No Specia	fy:			Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Extra that must be notified at	Completed	15. Deceden (Specify only highes	t's Education		16a. Deced	lent's Usual C	occupation	net of workin	20	16b. Kir	nd of Business/	Industry
121	within ene. than '	Idm	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L		lone during m etired)	OSI OF WORKI	g			
d 2	al Hygid other		17. Father's Name (First, Middle,	Last)			care		hor's Name	(First, Middle		civate e	estate
lan	should be marked of matic ever	To Be	Ernst Heinri	*						eid Me		ourname)	
ary	" = m =		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (S					r Town, State, 2	Zip Code)
Σ, Σ	ges 1 and 2 should nt of Health and Mer If item 27 Is marke or other traumatic		Georgette Baxte	r/ daughter		709 1	E. Mair	st.	Thu	rmont,	MD 2	21788	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health 6 Important: If item 27 Is any Injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Plac	e of Dispos etery, crem	sition (Name a natory or othe	place)	Di	ate	20c. Lo	cation - City or	Town, State
ij	it. Pa intmer intant: njury		4 □ Donation 5 □ Other (S)	pecify)	Haug		emeter	-	6/23/		·	iesburg	•
Ba	permit. Departr Importa any Inji		21. Signature of Funeral Service	Conses		1		ddress of Fac	nar			al Home	
			23a. Part I. Enter the disease, or	complications that caused	d the death. I			Main St	s cardiac o	WOODSD respiratory	oro,	MD 2179	Approximate
neg.	Physician		Immediate Cause (Final	only one cause on each li	ne.	1	<b>64</b> 1757 33			-			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	consequen	ce of).	4	ur.	17	,	,		
	Examiner	Ļ	Sequentially list conditions.	b. con	cest	w	1 h	eart	1	ail	un		
	rted nsit	Examiner	Sequentially list conditions, if a.y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts)	Dus to (or at	a consequen	ce of):					- (		
Ć,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):							
	ate be nysicia ne bur	<u></u>		d									
99	requires that the death certificate been signed by the attending physic hould be detached for use as the b	Physician/Medica	IF FEMALE:										
Вох	attend attend or use	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	ath 3 🗌	Ectopic pregi	nancy			2	3d. Date of del	
o	the de	ysic	1 ☐Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of deat	h 5□	Other (specif	y)				Month	Day Year
٠ <u>.</u> ت	that ned by deta		Part II. Other significant condition	ns contributing to death b	ut not resultin	g in the un	derlying cause	given in Part	1.	23e. Did	tobacco us	se contribute to	the cause of death?
Records,	w requires that the dispersion of the should be detached	ed by	renal fai	lure (c)	home	·c)				10	Yes 2	(No 3 □ Pr	obably 4 ☐ Unknown
ည်း ရ		Completed	atrial 1	ibrilla	tras	,				24a. Was		24b. Were au	topsy findings available
_ [	cate ha	E O	hy serten	Sim						auto perfo 1 □ Yes	psy ormed? 2 No	death?	completion of cause of 2 □ No
Vital	rnysician: this certific ral director,	å	25. Was case referred to medical examiner?	Hoositali					e of Death	(Check only o			
ō :	rnys r this ral dii	Certification: To	1 ☐ Yes 2 Doto 27. Manner of D ≢th	Hospital: 1 ☐ Inpatie	ent 2 ER/	Outpatient		Other: 4 🗆 N				☐Other (Spec	cify)
on !	ath. r: Afte e fune	#io	1 Natural 5 Pending	(Month, Day	y, Year)	Injury	'	Nork? 1 □ Yes 2 □		3d. Describe	now injury	occurred	
UIVISION	er deg recto	ii ii	3 Suicide 6 Could not determine		ury - At home,	farm, stree				3f. Location (	Street and	Number or Ru	ral Route Number,
5	ra officed in	Se								City or To	,		
DIVISION	To the Tropylation Amending Prysician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director, page 2 of the funeral director, page 3 of the funeral director, page 3 of the funeral director, page 3 of the funeral director and funeral di	edical	29a. Certifier (Check only one)  CertifyIng  Medical E	Physician: To the best of xaminer: On the basis of manner at	rexamination	dge, death and/or inve	occurred at the	ne time, date a	and place, a	nd due to the	cause(s)	and manner as	stated. to the cause(s)
4	orthin 2		29b. Signature and title of certifier	and manner sta	ited.			ense number				signed (Month	
<u> </u>	- S F 0		1/11	Win				580	14		29u. Date	2 2 -	, Day, rear)
		;	30. Name and address of person w	ho completed cause of de	eath (Item 23a	a) (Type, P	ſ	- 00	1		6	-	
			S PICKER	TMI	100	5	Cont	er T	Tu	rm	ut	MD	1788
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Lan	la l						
	riegistia		JUN 2 9 20	100 Single	10.1	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** EARLE MCKINLEY BARNES. 25 2009 7:55 A JR JUN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 441-34-0442 75 4/1/1934 Ok lahoma Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Ever-cinc must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔀 No Director Alexandria VA Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 22312 6439 Woodridge Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No White Specify ģ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Armed Forces 12 Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lenore C. Jones Boatright Earle M. Barnes, Sr. ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6439 Woodridge Road, Alexandria, VA 22312 Angela Barnes/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 6/26/2009 | Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of uneral Service Licens 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYELOGENOUS LEUKEMIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 🏋 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AARON W. FLANDERS

MC USN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barte

0101245663 (VA)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day

June 27, 2009 Physician 10:55 AM Louise Ward Borden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) **Funeral** 1 □ M 2 🔀 F 577-18-3724 Director 89 Oct 30, 1919 Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Directo MD Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 USA 9315 Friars Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ۾ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry T. Ward Howardine Gardiner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8919 Ridge Place Bethesda, MD 20817 Sally Bolger/daughter 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Final Journey Crematory 06/29/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Coing home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician a. Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐Yes 2X No 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice ٥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a. Certifler 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number : Koucetcheu, mo D 63748 June 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

JUN 29 2009

Jocelyn Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

32. Registrar's Signature

amend #5 Per FH G898ate of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician**  $\Delta I$ ANIEL (-unning /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** LOCH RAVEN BRAC NURSING CENTER (VA) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 2415 = 421 + 6553 Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. 65 Director <u>Maryland</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Evolution insist by retillined at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 360 Homeland Southway 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 64-65 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Raymond Murray Cunningham. M.D. Margaret Rose Cavey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trauonce. Joseph Gerard Cunningham (Brother) 8213 Rider Avenue, Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/2/2009 Owings Mills, Maryland MD Veteran Cem, Garrison 21. Signatur (Fungal Servic George)

Martin D. Lawson 22 Name and Address of Facility FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician MALIGNANT MELANOTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably this certificate has been sail director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide tycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EIMER M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 29 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 821 Physician OSOM IIL 0 25 2009 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 5 Days 1**⊘**M 2□F Hours 436-65-14 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo 10g. Citizen of What Country? 10e. Street and Number ed other than "natural", or Items 23a or event, the Medical Examiner must be a Funeral 14. Race -American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IA N N 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be oSom Is marked Item 27 Is marked r other traumatic e  $\alpha$ မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) MD lau 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Rurial 2 □ Cremation 3 □ Removal from State -27-09 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Wallaco Bacto, md, 2120 23a. Part Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause ( in all disease or condition prematurit. Extreme Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. by Physician/Medical attending I IF FEMALE If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 1 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Medical Certification: Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

erriv

Bunni

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

9000

38: Registrar's Signature

RES0000

FRANKLIN Square DR Balto md 21237

6-25-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:00 P. M 25, 2009 JUNE ROBERT F. DAGGETT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON GILCHRIST CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, **Funeral** Days Min Months 1 🙀 M 2 🗆 F Yrs 5/31/1930 NEW YORK Director 214-26-5427 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedcal Exprimer is ust by putting a once. 1 ☐ Yes 2 XNo Director BALTIMORE PARKVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 2219 LOWELLS GLEN ROAD APT. K Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 → No Specify: Ş Q WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE SCHOOL TEACHER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHIRLEY FERGUSON STANLEY P. DAGGETT ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) APT. K 21234 PARKVILLE, MD ANGELA DAGGETT/WIFE 2219 LOWELLS GLEN RD. Baltimore, I 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY MEM. TIMONIUM, MD 6/30/2009 GAPE TAIS and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO0217 23a: Part 1. Einter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final TOWSON, MD Approximate Interval Between Onset and Death Immediate Cause (Final Make DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) o. 9 Unknown 23e. Did tobacco use contribute to the cause of death? as been signed a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy page 1 ☐ Yes 2 ☐ No 2 1 □Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPILE Hospital: 1 ☐ Yes 2 📉 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I hours after death.

uneral Director: A
ely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled the Hospital The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlis

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 300 Lane Laure 6 8. Date of Birth (Month, Day, Sept 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 40 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4.5. A 20703 Funeral 300 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Black ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) da ЧĊ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1248es Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OY Sequentially list conditions Examiner Due to for as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the To the I

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) landover Hills MD 20784 4410 74th Ave Asha

State Registrar 31. Date filed (Month, Day, Year)

JUN 29

32 Registrar's Signature

and manner stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mar	-	epartment of H Certificate of L			. No. 2 0 0 9	20652
a F	hysicia	an	1. Decedent's Name (First, Middle, La.	-	20w/	KES		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	4a. Facility Name (If not institution, giv	(1)			Location of Death	6	4c. County of Death	10
	Examin	er	CROMUPELL	8710 Em	IGE R	D. BALTO.	mD.2	1234	1 - 8	
	uneral rector	ľ	22409340	7. Age	(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You 02-05	9. Birth Cou	place (State or Foreign intry) VA
land	ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
e Mary	a-f sh	ctor	MD		BALTIMO	DRE				1 Nyes 2 No
/ith the	or 28 be no	Director	10e. Street and Number			10f. Zip Code			. Citizen of What Cou	untry?
eath v	ns 23a must	Funeral	2267 PENTLAND DF	12. Was Decedent Ev	er in U.S.	21234  13. Was Decedent of Hill Yes, specify Cuba	ispanic Origin? (Spe		JSA 14. Race - Amer	
<b>3-UU30</b> 72 hours after death with the Maryland	r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2D No	an, Mexican, Puerto  Specify:	Rican, etc.)	Specify: B	LACK
1 <b>3-0030</b>	"natura edical E	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of worki		6b. Kind of Business/I	ndustry
ZIZI d within giene.	r than	dwo	Elementary/Secondary (0-12) 12TH	College (1-4or 5+		VAREHOUSEMAN	1		B. GREEN	
	d other	Be C	17. Father's Name (First, Middle, Last	)			18. Mother's Name	,	aiden Surname)	
arylan should be ind Mental	marked matic e	卢	HERMAN EDWARD BRO		100	Mailing Address (Street	ETHEL FO		City or Town State 7	(in Cade)
0, 0	7 is trau		19a. Informant's Name/Relationship ( ERIC BOATWRIGHT/C			267 PENTLAN				
of Hea	item 27 other tr		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other place			Oc. Location - City or	
Pag ment	int: t		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		CF	ROWNSVILLE	06/25	5/2009 0	ROWNSVILL	E, MD
ball permit. Departr	any inj		21. Signature of Funeral Service Lice	Chan	sh.	22. Name and Addre 2007–09 I	EASTERN AV	VE. BALT	IMORE, MD	RL. HM. 21231
-	3.18		23a. Part1. Enter the disease, shock, or heart failure. List only	plications that caused to one cause on each line	the detth. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	a		nic He	sour f	5,16a	16	
0	miner			Due to (or as a	consequence o	rj:				
EE.		ner	Sequentially list conditions, if any limit in the cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	f):				
ecuted	and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence o	f):				
<b>58 / 5U,</b> ficate be ex	physician and is the burial-transit			200 10 (0) 40 4	- sonoquonos s	···				
DO /	g phys as the	ledical		u.						
Hecords, P.O. box ba/bu,	ne attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of del Month	livery Day Year
hat the de	detached	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
dS, uires t	B 8	d by						1 □ Yes	s 2∏No 3∏Pi	robably 4 Unknown
VITAL RECORDS, Ician: The law requires t	e has been singe 2 should t	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
	certificate rector, pag	Be Cc	25. Was case referred to medical				26. Place of Deat	1 Yes 2 h (Check only one		2 110
	this ce al direc	To B	examiner? 1 ☐ Yes 2			patient 3 DOA			nce 6 Other (Spe	ecify)
On C	After this certificate harmonic funeral director, page	ion:	27. Manner o Teath  Natural 5 Pending investigation	28a. Date of Injury (Month, Day		njury Wo	ryat rk? ]Yes 2∐No	28d. Describe how	w injury occurred	
DIVISION OF VITA of or Attending Physician:	irector: n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not lead to determine	oe 280 Place of inju	ry - At home, far . <i>(Specify)</i>	m, street, factory, office		28f. Location (Str. City or Town,	eet and Number or R , State)	ural Route Number,
the Hospital or	To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best o	of my knowledge	, death occurred at the ti	ime, date and place	, and due to the ca	use(s) and manner a	s stated.
To the Ho within 24	the Fi	Medical	one)	and manner sta	ted.					
· P tily	Cor	2	29b. Signature and title of certifier	E ZVa	FIFME	-or mo	4100	\   23	6-23.	-09
(2)			30. Name and address of person who		eath (Item 23a) (	Type, Print)	100°	2 700	W. NOLW	th, Day, Year) _09 ws 21202
			31. Date filed (Month, Day; Year)	Market 32 Registra	ur's Signature	2 Marc	7 20	_ 1 P		
	St Regist	ate rar	JUN 2 9 20			haves				

June 19, **Physician** McKnight Kathryn Gross /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 941 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. Days 67 190-32-1734 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MD Brookeville Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 20833 Pages 1 and 2 should be filed within 72 hours after death with 230 Haviland Mill Road or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 □
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Administrative Grants Officer Of Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert E. McKnight Zimmer Bertha M. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
230 Haviland Mill Rd., Brookeville, MD 20833 19a. Informant's Name/Relationship (Type. Print) Ray A. Gross Jr. / Husband Department of Health ar Important: If item 27 is any injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Rose Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition ■ Burial 2 Cremation 3 X Removal from State 6/23/2009 Hermitage, PA 4 □ Donation 5 □ Other (Specify) Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee Dorota Marshall Leure V. Moustian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burtal-transit

P.O.

Division of Vital Records,

Examine Physician/Medical \$ Completed Be Certification: To

Medical

IF FEMALE:
23b. Was decedent pregn
in the past 12 months
1 □ Yes 2 M2No
O I I Introduce

1tepatorenal

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

and manner stated.

Due to (or as a consequence of):

1 Inpatient 2 ☐ ER/Outpa

9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19a.perFH, G892, 6/29/09, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

2009

Montgomery

USA

14. Race - American Indian, Black, White, etc.

White

National Institutes

1:15am

9. Birthplace (State or Foreign

PA

10d Inside City Limits

1X Yes 2 □ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23d. Date of delivery

Approximate Interval Between Onset and Death

Days

23e. Did tobacco use contribute to the cause of death?

	1 🗆 Yes	2
ſ		

3 Probably 4 ☑ Unknown

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

2	6.	PI	ace	of	De	at	h (	Cł	eck o	only	one	e)		
er:	4		Νι	ırsi	ng l	Ho	me	)	5 🗆	Re	side	nce	)	6
						т					-			

Specify)

' 1 ☑ Inpatient 2 🗌	ER/Outpatient	3 □ □	OA 4	□ Nursing H	ome 5 Residence 6 Other (Specify)
28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how injury occurred
28e. Place of Injury - At he building, etc. (Special	ome, farm, stree fy)	t, factor	ry, office		28f. Location (Street and Number or Rural Route Number City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Oth

9b.	Sign	ature	and	title	of o	certi	fier		
		D	el	0	re	4	D	ter	1

5 Pending investigation

6 ☐ Could not be

29c. License number H0065661 29d. Date signed (Month, Day, Year) 6/19/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Liver Disease

Syndrome

Hospital:

18101 Prince Debouale Sterre

31. Date filed (Month, Day, Year)

32. Registrar's Signature

0

State Registrar

within 24 hours a

To the Funeral

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ruth Viola Green ZET /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 9-29-1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 🔼 F Maryland 218-24-7764 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2X No Director MD Carroll Finksburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must t USA 14. Race - American Indian, 1535 Deer Park Rd. 21048 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene. Housewife Homemaker d 2 should be filed what and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Schmidt Viola Holman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ter 10120 Blue Marlin Dr. Ocean City, 21842 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is no any injury or other traur Patricia A. Nottingham-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Deer Park Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Deer 6-30-2009 Gamber, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fletcher Funeral Home, P.A. Thomas D. -Lehlus 254 E. Main St., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTIC Immediate Cause (Final SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( r as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 Other (specify) been signed by the should be detached o 9□Unknown or Vital Records, P. law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an s certificate has b lirector, page 2 s autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA this Date of Injury funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 il or Attending Fatter death. Division (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

in 24 hours after vector; Af the Funeral Director; Af Hospital To the I within 2

29a. Certifier 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D30263

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

FRANCIS KHOO -MD

110m 23a) (Type, Print)
200 MEMORIAL AVE, WESTMINSTER, MD 2/15

State Registrar

Medical

31. Date filed (Month, Day, Year)

2. Registrar's Signature

09-04878 Isacc Gamble

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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sacc Gamble	1- For State Certificate of Death Reg. No.	2009 2000
Physician/	1. Decedent's Name (First-Middle Last)  2. Date of Death Month Day Y	3. Time of Death  7ear 0935 hrs
Medical Examiner		ty of Death
	124 North Payson Street  Baltimore	NA
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YY) Months Days Hours Min. 10-11-1932	Faraina
nd show any cc.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  10c. City, Town or Location	10d. Inside City Limits 1 Ves 2 No
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23s or 28s-f show rother transatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		What Country?
r death with or items 23 c must be no Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Ra Windowed  15. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Ra Windowed  17. Was Decedent Ever in U.S.  18. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.)  19. Ra Windowed  10. Ves 2 No specify  10. Ves 2 No specify  11. Yes 2 No specify  12. Was Decedent Ever in U.S.	ace - American Indian, Black, hite, etc.
nore, MD 21215-0036 siges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by I	or Dates:  15. Decades 15 Education (Specify only highest grade completed). 16a Decades 15 Lisual Occupation (Sive kind of work done. 16b Kind of	Business/Industry
21215-0036 build be filed within 72 hour Mental Hygiene. marked other than "natt ic event, the Medical Exa- To Be Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surnar	me)
21215-(hould be filed and Mental Hygis is marked oth artic event, the To Be Cc	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To	
ore, MD ss 1 and 2 sho of Health and If item 27 is her fraumati	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location recognition of other place)	on - City or Town, State
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed with Department of Feath and Mental Hygiene, Important: If item 27 is marked other ti injury or other traumatic event, the Med	21. Signal up of Funeral Service Localisee 22. Name and Address of Facility 270 For at t	etemine, md.
Physician /Medical	23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or laiture. List only one cause on each line.	heart Approximate Interval Between Onset and
Examiner	Immurate Cause (Final disease or condition resulting in death)  a. Prostate and Kidney Cancer  Due to (or as a consequence of):	Death
ted 	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
60, ate be executed hysician and burial - transit Medical Exa		
60, ate be execu ohysician and be burial - tra	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date	e of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E.		n Day Year
O. B at the d 1 by the tached		ontribute to the cause of death?
S, P.O.  irres that the signed by to deed detache	atherosclerotic cardiovascular diseasee 1 Yes 2 No	3 Probably 4 ✔ Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	24a. Was an autopsy performed? 1	b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
cian: T certificate to the Company of the Company o	a 25. Was case referred to medical 25. Place of Death (Check only one)	
FVit Physic er this c	examiner?    1   Very   Yes   2   No   No   No   No   No   No   No	6 Other: Scene
ion o tending eath for: Afte the fune the fune	1   Natural   5   Pending   2   Accident   Investigation	
Division o spital or Attending tours after death.  meral Director: After filled in by the function:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nur or Town, State)	mber or Rural Route Number, City
Division of Vital Records.  To the Hospital or Attending Physician: The law requivatiful 24 hours after death.  To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should Medical Certification: To Be Complete		nd due to the cause(s)
<b>■</b>   ≥	29b. Signature and title of certifier  29c. License number  29d. Date si  O.C.M.E.  OCME  June 26,	signed (Month, Day, Year)
	30. Name and address of person who completed dause of death (Item 23a)	
	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 20ď **Physician GOTTESMAN** 12:33 PM LEONARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE Date of Birth (Month, Day, Year) 10/17/1930 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 192-22-9408 78 Director Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hedical Ever, in per rutillised at 1 ☐ Yes 2 No Director BALTIMORE REISTERSTOWN MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 3 USA 12020 REISTERSTOWN ROAD 21136 **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No NA' If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married NAVY Specify: WHITE 3altimore, Maryland 21215-0036 1 □Yes 2 No à 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN **JANITORIAL** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KRAVITZ HARRY GOTTESMAN SARA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trace once. 2420 PLAINHURST WAY, REISTERSTOWN, MD 21136 ROBYN WINEKE / DAUGHTER 20b. Place of Disposition (Name of ARIENTALE TRANSPORTED PROPERTY ACE) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date Pages 1 CŎNGŘEĠĀŤÌON BALTIMORE, MD 06/24/2009 4 ☐ Donation 5 ☐ Other (Specify) AMUNO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ~eavs disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐Pending investigation 1 RNatural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. To the I within 2. To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ひろてちてろ 27, 2009 30. Name and address of person who com leted cause of death (Item 23a) (Type, Print) ZIDEL 21136 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 9 **200**9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 1,30 per dr., g892,06/29/09dh Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1<sup>Day</sup> 2009 Marcus Hall **Physician** Hall, Marcus 11, 6:30 AM M June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kent Heron Point Nursing Home Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Dec 13, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F Months Michigan 94 119-03-0353 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 □Yes 2 □No Completed by Funeral Director MD Kent Chestertown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 501 E. Champus Avenue 21620 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 ☐ I If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced 41-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)  $1\dot{2}$ clergy religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marcus Brown Hall Sr Edith Chase ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21620 Priscilla Hall 501 E. Champus Avenue Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature - Euneral Service Sicensee Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE Physician CONGESTIVE /Medical Due to (or as a consequence of): **Examiner** MITRAL REGURGITATION Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 🖺 Yes 2**X** No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy perform 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury No true.

Within 24 hours after .....

To the Funeral Director: A 1 🗌 Yes 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

0

31. Date filed (Month, Day, Year) State JUN 29 2009 Registrar

29b. Signature and title of certifier

Helen A. Noble, MD, 122 Speer Road, Chestertown, MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0041587

29d. Date signed (Month, Day, Year)

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		FOR	epartment of Health and Menta	al Hygiene 2009 206	58		
		Troglova	Certificate of Death	Reg. No.			
Physici	an	Decedent's Name (First, Middle, Last)	2. Dat Mo	e of Death 3. Time of Death 1. Time of D			
/Medic				NE 26 2009 11:26	PM		
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  13 ALTIMORE	4c. County of Death			
		HARBOR HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birth	4 V If Under 1 Vear   If Under 24 Hrs   9 Det	te of Birth 9. Birthplace (State or	Foreian		
Funeral Director		21/-38 9500	Months Days Hours Min. (Mo	/6/1941  9. Bittiplace (State of Country)  MD			
		Usual Besidence of Decedent					
rylan show	_	10a. State 10b. County 10c. City, Town	Baltimore City	10d. Inside City			
e Ma Ba-f s	cto	IIID IN/II			: [] NO		
/ith th	Director	10 W. Fort Avenue	10f. Zip Code 21230	10g. Citizen of What Country?  USA			
s 23e	Funeral						
item item	듄	11. Marital Status  1 □ Never Married   1 □ Never Married   1 □ Yes 2 ▼ No	<ol> <li>Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,</li> </ol>	etc.) Black, White, etc.			
urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No Specify:	Specify: White			
72 ho	ed	15. Decedent's Education 16a. [ (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working	16b. Kind of Business/Industry			
thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	Service			
ed wi	Completed		ar Maid/Waitress				
be fill half he ot	Be	17. Father's Name (First, Middle, Last) Franklin Cunningham		Middle, Maiden Surname) Shortridge			
hould d Me mark matic	ဍ		Mailing Address (Street and Number or Rural Route				
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show wither traumatic event, the Medical Examiner matte profitted at		Philip E. Harrell /Husband 1	0 W. Fort Avenue, B.	altimore MD 21230			
Heal Heal tem 2		20a. Method of Disposition 20b. Place of I	Disposition (Name of Date	20c. Location - City or Town, State			
Pages nent of ant: If its		1 Burial 2 Argenetry  1 Donation 5 Other (Specify)	crematory or other place) Crematory 06/29/	2009 Hanover Maryla	and		
- t ਦ = .		21. Signature of Spineral Service Licensee Victor P. Dod	a 22. Name and Address of Facility				
Departing the permit of the pe		) iw	Charles L. Stevens 1501 E. Fort Avenu	e, Baltimore MD 212	230_		
		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart fallure. List only one cause on each line.		ratory arrest, Approximate Interval Betw	een		
Physician		Immediate Cause (Final disease or conditiona, SEPS1S SECO	NDARY TO PNEU	MONIA 3 WEE			
/Medical		resulting in death)  Due to (or as a consequence of					
Examiner	_	Sequentially list conditions, b. PANCYTOPE	NIA	IWE	EK		
sit sed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	):				
al-trar	xan	that initiated events c. Due to (or as a consequence of	):				
sician buria	E E						
ificate g phy is the	edical	u.					
n cert	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2 Catania avagnancii	23d. Date of delivery			
deat	sicia	in the past 12 months?  1 ☐ Yes 2 ☑ No  1 ☐ Yes 2 ☑ No  1 ☐ Yes 2 ☑ No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Ye	ear		
at the I by the	Physician/M	9 Unknown	T and		-41-0		
es the	þ	Part II. Other significant conditions contributing to death but not resulting in	and the same of th	Be. Did tobacco use contribute to the cause of de			
een s	ted	CHRONIC OBSTRUCTIVE PULM	DNARY DISEASE	1 X Yes 2 No 3 Probably 4 U	KIIOWII		
law has b	Completed	HYPERTENSION, HEPATITIS		la. Was an autopsy findings a prior to completion of ca death?			
r: The	ပိ		<del></del> _	□Yes 2⊠No 1□Yes 2□No			
siciar certif rector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Chec				
Physical disprayment	. To	1 ☐ Yes 2 ☑ No	me of 28c. Injury at 28d. Do	☐ Residence 6 ☐ Other (Specify) escribe how injury occurred			
th. : Afte	tior	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) Ing 2 ☐ Accident investigation	ury Work? M 1 □ Yes 2 □ No				
Atter	ifice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm		cation (Street and Number or Rural Route Numb ty or Town, State)	er,		
safte safte at Dir	Certification:	4 ☐ Homicide Solominios building, etc. (Specify)	G,	y or rown, States			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, the discal Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and du or investigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)			
u) (i) —	70	The state of the s	29c. License number	29d. Date signed (Month, Day, Year)			
Fo the within Fo the comp	Med	29b. Signature and title of certifier	290. License number				
To the vithin comp	Med	29b. Signature and title of certifier  MD		JUNE 26,200	PC		
To the within to the comp	Med	30. Name and address of person who completed cause of death (Item 23a) (7	RES Ø Ø Ø I	JUNE 26,200			

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

0	0	-	-	1
6.	U	D	J	

		1	For State Registrar	Ce	rtificate of Death	,	Reg. No.	201	) 0 -
	Physicia /Medio	an	1. Decedent's Name (First, Middle, Las Luella S. Hu	nter		2. Date of De Month June	ath 25, Day 2009 Year	3. Time of De 6:30	eath <b>a</b> M
0	Examin		4a. Facility Name (If not institution, give 6003 Sachem Roa		4b. City, Town, or Location of Dec Oxon Hill	ath	4c. County of Death		s
	Funeral Director		5. Social Security Number 418–36–8206 6. Se	ox 7. Age (In yrs. last birthday 79 Yrs.	If Under 1 Year   If Under 24 Hi   Months   Days   Hours   Mil	). (Month, Da	th 9. Birth Cou	place (State or F intry)	Foreign
	e Maryland la-f show	Director	Usual Residence of Decedent  10a. State 10b. County Prince 0	George's Oxon Hi				10d. Inside City 1 <b>X</b> Yes 2	
	3a or 28	al Dire	10e. Street and Number 6003 Sachem D	rive	10f. Zip Code 20745		109. Citizen of What Cou USA	intry?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is it effect in a rough on other traumatic event, it is it effect in a rough once.	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎛 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 □Yes 2XXIIo Specify:	(Specify Yes or No orto Rican, etc.)	14. Race - Amer Black, White, Specify:		
Maryland 21215-0036	I within 72 ho giene. r than "natui ine Medicel	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. Deci de completed) (Giv College (1-4or 5+) 4	edent's Usual Occupation be kind of work done during most of w DO NOT use retired) Manager	orking	16b. Kind of Business/Ir	-	:
land	uld be fileo Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) William <del>Si</del>	nglston Singleto		ame <i>(First, Middle,</i> Clara W	, Maiden Surname) hatley		
Mary	nd 2 shou lith and IA 27 is ma r trauma		19a. Informant's Name/Relationship (7 Fronia Bryant		ing Address (Street and Number or 1) 3 Sachem Driv				
Baltimore,	ages 1 ar ent of Hes nt: If item y or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Hemoval from State 7 rdon+	matory or other place)	Date /25/2009	20c. Location - City or T		
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licens	/	2. Name and Address of Facility Maryland Cremati	lon Servi	.ces		
	Physician /Medical Examiner	_	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):  b. ACRAL	λ	iac or respiratory a		Approximate Interval Betwe Onset and De	en eath
M09289	ortificate be executed ing physician and e as the burial-transit	Medical Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):  d					
P.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Ye	ar
rds, F	quires that en signed b uld be det:	ed by Pl	Part II. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.		tobacco use contribute to Yes 2 ☑Ño 3☐ Pro		
Division of Vital Records,	: The law re cate has bee page 2 sho	Completed by				24a. Was auto perfo 1 ∐Yes	ormed?   death?	topsy findings av completion of cau	railable use of
Vita	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:	Tau.	eath (Check only			
on of	ding Phys I. After this funeral di	ion: To	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	THE SELECTION ACTIVATION		idence 6 Other (Specification) occurred	cify)	
Divisio	To the Hospital or Attend within 24 hours after death To the Funeral Director. A completely filled in by the f	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location ( City or To	(Street and Number or Ru wn, State)	ıral Route Numbe	Ð <i>Г</i> ,
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Phr 2 Medical Exam	ysiclan: To the best of my knowledge, dea ilner: On the basis of examination and/or and manner stated.	th occurred at the time, date and planvestigation, in my opinion, death of	ace, and due to the courred at the time	e cause(s) and manner as , date and place, and due	s stated. to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier	Herr	29c. License number 5 3 2 3 5		29d. Date signed (Month	h, Day, Year)	-
	Ve	-	30. Name and address of person who of Darryl Hill, N	completed cause of death (Item 23a) (Type 1.D. 13635 Baltin	Print) More Avenue, L	aurel,	MD 20707		

State Registrar 31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE 25 Day 2009 **Physician** 9:58 ΑМ JUNG S. HONG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1 □ M 2 💢 5/4/1949 Korea 60 **Director** 212-51-8521 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State in than "natural", or items 23a or 28a-f show the Medical Example of most be motified at 1⊠Yes 2□No Director MD Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10706 Muirfield Drive 20854 Korea death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Ext. of the sore. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Asian δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Tailor Self employed unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TaeGap Kang NohSook Park ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Phelps Hill Ct. Derwood, Maryland 20855 Ted Kim/ Son-in-law 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. 6/30/2009 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshalls Funeral Home 20011 4217 Ninth street, NW Washington, DC 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** New Q aute respiratory /Medical Due to (or as a consequence of): Examiner ante Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-transit To the Hospital or Atteriding Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed 1⊉¥es 2□No After this certification funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending iours after death. neral Director Aft rilled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number TURNEL medital D67974 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 PARIZAD TORABI-PARIZI 31. Date filed (Month, Day, Year)\_ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 pet FH G892 6/29/09 TI

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:50 PM Month Year **Physician** 2009 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 50-Hmore will If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 4/2/1967 Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral √**M 2□ F Months 220-25-7615 MP Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show r items 23a or 28a-f shor 1 ☐Yes 2 ☐ No Director MD n/a Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6523 O'Donnell St. Apt. 21224 USA Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: black traumatic event, the Mudical Ever. 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Landscaper BaltimoreCity 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Leonard Harris Dorothy Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Derrell J. Harris (son) Balto, N. Curley St. Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery July 3,2009 Balto,Md. 4 Donation 5 Other (Specify) n ure of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) ailure **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Icoholisn Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 1 □Yes Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autonsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient 28 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006776 an a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8A, Pa egistrara Signatur 31. Date filed (Month State

Registrar

# Baltimore, Maryland 21215-0036

	-
Division of Vital Records, P.O. Box 68760,	senital or Attending Dhysleian: The law requires that the death certificate he executed
Records,	The law requires the
of Vital	Dhyeldian
Division	senital or Attending

1. Decedent's Name (First, Middle, LIsabelle E.	.ast)					2. Date of Dea	th	1	3. Time of Death
Isabelle E.						Month	Day	Year	
4a. Facility Name (If not institution, g	James			4h City Town	n, or Location of Death	06	17 4c Co	2009 unty of Death	6:20 A <sup>N</sup>
Heartland Nursi					sville			nce Ge	
	Sex _ 7. Ag		birthday)	If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreigntry)
223-40-0403 Usual Residence of Decedent	1□ M 2Å F	86	Yrs.	Months Da	iys Hours Min.	02/22/1	923_		GA
10a. State 10b. County		10c. City, To	own or Lo	cation			_		10d. Inside City Limit
MD Prince	George's	Hyatt	svil	1e					1 X Yes 2 N
10e. Street and Number				10f. Zip Cod	de		10g. Citizer	of What Cou	intry?
6500 Riggs Rd.									
11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14.	Race - Ameri Black, White,	
	If Yes, Give	No		1∐Yes 2⊠	No Specify:		Sp	ecify: Blad	ck
			60 Dooo	dont's Heural Or	counation		16b Kind	of Business/Ir	ndustry
(Specify only highest g	grade completed)		(Give	kind of work do DO NOT use re	one during most of worl stired)	king	TOD. Tilla	01 20011030711	rados y
Elementary/Secondary (0-12)							Willi	am C.	Smith
17. Father's Name (First, Middle, La		J 120	00100			ne (First, Middle,	Maiden Su	rname)	
					Judson	Wright			
		1	19b. Mailir	ng Address (St	reet and Number or Ru	ral Route Numbe	er, City or T	own, State, Zi	ip Code)
20a. Method of Disposition	15ter	20b. Place	e of Dispo	sition (Name o	f	Date		tion - City or T	own, State
				-		2/2009	Suit1	and. M	m
		LINC							
by man	ishall								
shock, or heart failure. List on	omplications that caused ly one cause on each li	d the death. [							Approximate Interval Between Onset and Death
disease or condition	_a. Caro	diopulr	nonar	y Arres	st				
resulting in death)	1	•							
Sequentially list conditions,	U							-	
cause. Enter Underlying	Due to (or as	a consequen	ice oi).						
that initiated events resulting in death) Last	c Due to (or as	a consequen	ice of):						
		·	,						
	d								
IF FEMALE:	23c. If yes, outcome	e of pregnancy	у				23	d. Date of deli	very
in the past 12 months?								Month	Day Year
9 ☐ Unknown	9 🗆 Unknown								
Part II. Other significant conditions	s contributing to death b	but not resultin	ng in the u	nderlying cause	e given in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
						1 🗆 `	Yes 2□	No 3□ Pro	obably 4 X Unknow
						24a. Was	an	24b. Were au	topsy findings availal
						perfo	rmed?	death?	completion of cause of
25. Was case referred to medical	1				26 Place of Dog			1 ∐ Yes	2 <b>X</b> No
examiner?	Hospital:	iont OFTER	(Outratio	nt 2 🗆 DOA	Other:			Other (Sno	0(64)
27. Manner of Death	28a. Date of Inj	jury 28	Bb. Time o			1			ony)
1 Natural 5 Pending  2 □ Accident investigat		ay, Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No				
3 ☐ Suicide 6 ☐ Could not		njury - At home	e, farm, str	reet, factory, off	fice	28f. Location (	Street and	Number or Ru	ıral Route Number,
4   Homicide	building, e	etc. (Specify)				City or 101	vn, State)		
(Check only 2 Medical Ex	caminer: On the basis	of examination	edge, deat n and/or ir	th occurred at to	the time, date and place my opinion, death occi	e, and due to the urred at the time,	cause(s) a date and p	and manner as lace, and due	s stated. to the cause(s)
	and manner s	nateu.		29c. Li	cense number		29d. Date	signed (Monti	h, Day, Year)
1 ( Wushing	Q MAN			-10	F20		6/01/	2000	
MACH	7 111)	dooth (Itam Of	20) /Tum -		529		6/21/	2009	
20 Nome and addressed at a service									
30. Name and address of person where Victor Onyejiaka					eenbelt MD	20770			-
	Usual Residence of Decedent  10a. State	Usual Residence of Decedent  10a. State	Usual Residence of Decedent   10a. State   10b. County   10c. City, T   MD   Prince George's   Hyatt   10b. Street and Number   10a. State   10b. County   10c. City, T   MD   Prince George's   Hyatt   10b. Street and Number   10a. State   10b. County   10c. City, T   MD   Prince George's   Hyatt   10b. Street and Number   10c. City, T   MD   Prince George's   Hyatt   10c. City, T   10c. City, T   Hyatt   10c. City, T   10c. City, T	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Lower Manager   10b. County   10c. City, Town or Lower Manager   10b. County   10c. City, Town or Lower Manager   10b. Street and Number   10c. Street   10c. Stre	Usual Residence of Decedent   Usual Company   Usual Residence of Decedent	Susual Residence of Decedent   10a. State   10b. County   10b. City, Town or Location   10a. State   10b. County   10b. County   10b. City, Town or Location   10b. City, Town or	223-40-0403   10 M 28 F   86 Yrs.   Morcins   Days   Hours   Min   02/22/2/3	Securitary   Sec	Total Presidence of Decederal   Total State   Total Stat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend19a-b, per Int C893 7/15/09 TT

State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** a JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner MONIUM Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Sex 7. Age (In vrs. last birthday **Funeral** 1₽M 2□ F Months Days Hours Min Director Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condany (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, Itea once. Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 2009 19b. Mailing Address (Street and Number or Rural Route Number, City or fermant's Name/Relationship (Fyce Print) Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specify) 4 ☐ Donation Funeral Service Lice Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Pal 1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760. or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical LOVLIEST JACKSON 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Vear 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury i Director: After to in by the funera 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C To the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examiner Nurse Practitions) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
JUN 2 9 2 State Registrar

April Johnson

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

Month

Randallstown

3. Time of Death

4:45 p

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

Maryland

Black

fly Year

4c. County of Death

ZOE

Baltimore

U.S.A.

Own Home

Hanover, Maryland

Approximate Interval Between Onset and Death

Year

14. Race - American Indian, Black, White, etc.

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

2 🗌 No

Smith Avenue Baltimere MD

Seasons Hospice of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 ☑ F Mar 28, 1963 Director 215-88-0375 46 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a fixed Exactic must be notified any injury or other traumatic event, if a fixed Exactic must be notified. Director Brooklyn Park Maryland N/A 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21225 3504 4th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvia Johnson Linwood Johnson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2505 Huron Street Baltimore, Maryland 21230 India Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/01/09 4 Donation 5 ☐ Other (Specify) St. Rest Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** End Stage disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Alcohol burial-tran and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. þe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Spec 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this Certification: To funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

1 ☐ Yes

State Registrar

1 - For State Registrar

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

5 Pending investigation

6 ☐ Could not be

Year)

determined

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day,

Attending

death.

lospital or Attendi I hours after death. uneral Director: A

To the Hospital o within 24 hours af To the Funeral Di

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

1 ☐ Yes 2 ☐ No

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) OS AM Year ONES TUNE 2009 YLVESTER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPITAL SECOURS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days 1 **№** M 2 🗆 F Jan 24, 1941 Maryland 217-40-4029 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 ☐ No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A 843 North Bentalou Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Kane Transfer Company Elementary/Secondary (0-12) Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Ricks James Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 843 North Bentalou Street Baltimore, Maryland 21216 Catherine Jones 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 07/01/09 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery & Chapel 21. Signature of Funeral Service Lig 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final CANCER LUNG disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ⊒Yes 2 □ No a 1 Inknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-transi

been signed by the should be detached

s certificate has be lirector, page 2 sl

this

After

reral Director:

within 24 hours a To the Funeral D

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

10a State

Director

Funeral

2

Completed

Be

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Exami

Physician/Medical

<u>\$</u>

Completed

Be

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Certification:

Medical

29a. Certifier

Examiner

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene.
n 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, 11.1 M. cit.al. E. Aminer must be notified at

Health a

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBSTRUCTIVE PULMONARY

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

IMMUNODEFICIENCY VIRUS INFEGTION

rmed∕ 2 ∐No 1 ∐Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

MARYLAND

25. Was case referred to medical examiner? Hospital: 1∐ Yes 2 🛂 No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

5 Pending investigation 1 **☑ Na**tural 2 Accident 6 □Could not be 3 Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

HOSPITAL

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BON MILLEY 1 Homas 32. Registrar's Signatur 2 9

Registrar

			For State Registrar	State of Maryland		tificate of l			eg. No.	U 9	20000
	Physici	an	1. Decedent's Name (First, Middle, Last Doris There					2. Date of Deal Month	Day	Year	3. Time of Death 8:25a M
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County	of Death	
_			1206 Kruger A			Ros	sedale If Under 24 Hrs.	8. Date of Birth		ltim	
	Funeral Director		5. Social Security Number 216-20-8208 6. Sec. 1 [	x	Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Coun	ace (State or Foreign try) MD
	yland now at		10a. State 10b. County		, Town or Lo					1(	0d. Inside City Limits
	he Mar 8a-f sh ptiffed	ector	MD Baltim	ore	Ros	sedale					1 X Yes 2 □ No
	th with the 23a or 2	Funeral Director	10e. Street and Number 1206 Kruger Ave	nue		10f. Zip Code 21:	237		0g. Citizen of V US.		try ?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	- 1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ሺ No		pecify Yes or No- o Rican, etc.)		e - America k, White, e : Wh	
2	"natul	leted	15. Decedent's Edi (Specify only highest grad	le completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind of Bu	siness/Ind	fustry
212	d withir giene. ir than the Ma	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ssing Gu			Educa	tion	
Maryland 21215-0036	ild be filed lental Hygid <b>ked other</b> ic event, the	To Be C	17. Father's Name (First, Middle, Last) Walter Nadolny	Sr.			18. Mother's Nan Helen	ne <i>(First, Middle, I</i> <b>Stoda</b>	Maiden Surnam	e)	
Mary	and 2 shouesalth and No 27 is mar	-	19a. Informant's Name/Relationship (7) Linda Kurant / Day	<sub>(pe. Print)</sub> ughter	1	ng Address (Street A					Code)
Baltimore,	Pages 1 and 2 ment of Health ant: If Item 27 ury or other tra		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Other (Specify,	nemoval from State   1		sition (Name of matory or other place rematory	<sup>ce)</sup> 6/	Date 27/2009	20c. Location - Hano	City or To	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens			2. Name and Address Maryl		mation	Servi	ces	1203
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. 701C	110	er the mode of dyin	ng, such as cardiad	or respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as Consequ		ARY	104 No	n Ten	Sian		
4	po tis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of	RTEN					
D.	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c	<del></del>	3171617	2/3/9				
68760,	ate be nysicia he buri	edical		d							
.O. Box 6	ath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	⊒Ectopic pregnancy ∃ Other (specify)	/			e of delive	ery Day Year
о_	w requires that the d been signed by the should be detached	by Phy	Part II. Other significant conditions co		ılting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
ords	equire sen sig ould b	ted b	0	RAIS OUT	2.5			1 🗆 Y	es 21 No	3 Prob	ably 4 Unknown
Vital Records,	The law ite has be	Completed	G /67	RIC BLE	15111	NG		24a. Was a autop: perfor 1 Yes	sy med?	Were auto prior to con death? I ☐ Yes	psy findings available mpletion of cause of 2 \( \) No
/Ita		Be C	25. Was case referred to medical examiner?					ath (Check only or			
or	Physic rthis c	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐  28a. Date of Injury	ER/Outpatier 28b. Time o	nt 3 DOA Oth f 28c. Injur	4 LI Nursing F	lome Resid			y)
lon	ath. rr: After	ation	1 Accident  5 Pending investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 ∐ No	200. 200.120 11	o., .,,a.,		
Division or	al or Atte s after de il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, is	Medical C		vslclan: To the best of my knowiner: On the basis of examinal and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier	stat de	am l	29c. Licens			29d. Date signe		
	3		30 Name and address of person who of	ompleted cause of death (Item	23a) (Type,	Print)	48025 E>AG	Ave,	Balturk	10:	21237
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture						

State Registrar

			1-	For State		State	e of M	larylan	d / Depa	artmen rtificat				ental Hy	giene Reg. No	000	10	2066
			1. D	Registrar ecedent's Name	e (First, Middl	e, Last)			001	inioar	0 01 2	Joann		2. Date of De	eath	The Sect of	1	3. Time of Death
	Physici			Dobosol	Torma	Vnoogo								June 2	28, _	<sup>y</sup> 2009	ear	10:32 A <sup>M</sup>
No.	/Medi Examir		4a. I	Facility Name (/	f not institution	Nneess	d number	·)		4b. City,	Town, or	Location	of Death	ounc 2		. County of	Death	20.02
	- Zaiiiii			Anne Ai	runde1	Medical	Cen	ter		Anna	apol:	is				nne Ai	cund	lel
	Funeral		5. S	ocial Security N	umber	6. Sex			last birthday) Yrs.	If Under Months	1 Year Days		Min.	8. Date of Bir (Month, Di 11/13/	rth ay, Year)	9	. Birthp	place (State or Foreign
	Director			218-56		1 □ M 2 <b>½</b>	F	26	Yrs.	WOTHERS	Days	110013	14.11.	11/13/	1952	2 V	lashi	ngton DC
	pu »		_	al Residence of State	Decedent 10b. County			10c City	y, Town or Lo	cation							1	0d. Inside City Limits
	sho	ō	Toa.	MD	Calve	<b>~</b> +			nce Fr		ick							1XiYes 2 □ No
	the M	ect	100	Street and Nur				1111		10f. Zip					10a Ci	tizen of Wh	et Cour	ntry?
	with with be or	Ö	100.			D11				101. 21	206	7.0			-	U.S.A		,
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(0	fter o	Ē		Never Marri	ed 2□ Mar	Arme	d Forces es 2√ , Give	?						Rican, etc.)			White,	
03	al", o	þ	3	Widowed	4 Divorced	If Yes Year	or Dates:			1 □Yes	2 <b>X</b> No	Specify	<b>:</b>			Specify:	MUTI	-e
5-0	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show sht, the Medical Examiner must be notified at	Completed by Funeral Director		(Spec	15. Deceden	t's Education st grade comple	ted)		16a. Dece	dent's Usua kind of wo	al Occupa	ation during mos	st of workir	ng	16b. K	(ind of Busin	ness/Ind	dustry
121	ithin ne.	I de	EI	lementary/Seco			ge (1-4or	5+)		kind of wo DO NOT us		)				1		
2	filed withir Hygiene. Sther than sht, the	ပိ	17	12 Father's Name	Eirot Middlo	/ act)			_Hair	iress	er	18 Moth	orie Name	(First, Middle		metol	ogy	
Maryland 21215-0036	ould be f Mental I arked of atic eve	Be c	17.			Lasij							na Ro		, maraoi	, 00.,,,,,,,,,		
Z	2 should I and Men Is marke	၉		Atlas .		hip (Type. Print)			19h Mailir	na Address	(Street a			l Route Numb	ner. City	ar Town. St	ate. Zio	Code)
<b>S</b>	and 2 s ealth ar n 27 is ier trau					/Mother								r Hill:			784	,
ē,	_ T & ±			Method of Disp	osition			20b. P	Place of Dispo emetery, crer					ate		ocation - Ci	ty or To	wn, State
Baltimore,	Pages nent of I int: If ite			1 ☐ Burial 2 E 4 ☐ Donation		3 ☐ Removal f	rom State	; I	nt Grenz				06/2	9/2009	Han	over.	Maı	cvland
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Ä	Depar Impo any Ir			Laura	c. C. 4/2	andesty	Mo	1197	7.5	522 C	onne	11ey	Driv	e, STe	.N,	Hanov	er,	MD 21076
	Physician		Imn	nediate Cause (	ne disease, or rt failure. List Final	complications to only one cause						g, such as		r respiratory a	arrest,			Approximate Interval Between Onset and Death
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Box (	certi nding use a	M/C		EMALE: . Was decedent	pregnant			e of pregna								23d. Date	of delive	ery
B	death atte	Physician/M	230	in the past 12	months?			2 ☐ Feta at time of d		☐ Ectopic p ☐ Other (sp		4				Mont		Day Year
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	ires that the de signed by the a be detached to	by P	Part	II. Other signif	icant conditi	ons contributing	to death	but not resu	ulting in the u	nderlying c	ause give	en in Part	I.	23e. Did	tobacco			he cause of death?
ğ	w require s been si should b	ed	_											1 🗆	Yes 2	2 □ No 3	Porol	bably 4 🗆 Unknown
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ď	The ate h	E												perf	ormed2 2 PH	. I de	ath? ]Yes	2 2100
'ita	sician: The law s certificate has t irector, page 2 sl	Be	25.	Was case refer	red to medica							26. Plac	e of Death	(Check only				
of Vital Records,	Physician: r this certific ral director, p			1  Yes 2 ¥		Hospital:	1 mpat	ient 2 🗆	ER/Outpatier			4 LI N	lursing Hor	ne 5□Res	idence	6 ☐ Other	(Specia	fy)
ū	ing P	Certification: To		Manner of Deat 1 ☑ #atural	5 Pendin	19 (	Date of In Month, D	ury ay, Year)	28b. Time of Injury		28c. Injury Work	y at		28d. Describe	how inju	iry occurred	İ	
Sio	tea h tor the f	cat		2 ☐ Accident 3 ☐ Suicide	investi 6	not be	N 4 l -	in a A to a		M		Yes 2□		206 1	/O4	and Advance on	D.	al Davita Number
Division	or Al	rti		4 Homicide	determ	inga   28e. F	uilding, e	itc. (Specif	ome, farm, str y)	eet, ractory	, описе		4	City or To			or mura	al Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after dea h.  To the Funeral Director After this certificate hat completely filled in by the funeral director, page		29a	. Certifier	1 Certifyin	ng Physician <sub>ท์</sub> โ	o the hes	t of my kno	wledge, deat	h occurred	at the tir	ne, date s	and place	and due to the	e cause(	s) and man	ner as	stated.
	e Hos 24 h e Fun etely	Medical		(Check only one)		Examiner: On t		of examina										
	Vithin Vithin Yound	Me	29b	. Signature and	title of certifie	, V				299	License	e number	<i>~</i> ,	,	29d. D	atersigned	Month,	Day, Year)
				<b>&gt;</b> 1	Ken.					7	1/4)	54	701		l li	193	de	07,
			30. 1	Name and addr	ess of person	who completed	cause of	death (rem	n 23a) (Type,	M		1	1 11.0	cal A	1/2	128	110	21.ta.
				St	oller	/ 1/e	Sc	إحكا	1	Ju.		į.	# 170F	100	V	/		Tic
	Sta	ite	31.	Date filed (Mon	th, Day, Year)		2. Regis	rar's Signa	ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25 1:25 PM Kramer **Physician** 7004 125 June nar 65ep /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Burtonsville Montgomery Holy Cross Sanctuary If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 81 Rhode 3/8/1928 Island Director 039-16-6100 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'naturai", or items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 X No Director Prince Georges Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20707 7656 E. Arbory Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No Specify. Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown 2 Charles Rudolf Kramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7656 E. Arbory Court, Laurel, MD 20707 Nancy E. Kramer/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 6/26/2009 Hanover, Maryland 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Se of e Licens MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebrovasculur /Medical Due to (or as a consequence of): AtriALS **Examiner** brill at Se puentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐Pregnant at time of death 5 ☐ Other (specify) 9∏1Inknown 9 Unknown has been signed by ge 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Maymer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

To the Hospital or Attending Physician: within 24 hours after uccom.

To the Funeral Director: After of the Funeral Director of the funeral part of the funeral of the

> State Registrar

one)

29b. Signature

31. Date filed (Month, Day,

and title of oe

Main Street Suite 200 Reistestown, Md 21136 22 MD 32. Registrar's Signature 9 2009

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0053337

29d. Date signed (Month, Day, Year)

June 25 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary 1- State Amend Items 24a,25,27	land / Der per dr	partment of \$892,067 eftificate of	Health Death	and Mental H	ygiene Reg. No.	2009	3 20	669
· j	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of D	eath Day	Year	3. Time o	
	/Medic		Jasper Lawhorne					1	2009 Year	7:25	PM M
	Examin	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of imore	if Death	4c.	County of Deat	h	
. 1	F		3115 Windsor Avenue  5. Social Security Numberunk 6. Sex 7. Age (Ir	n yrs. last birthda			24 Hrs. 8. Date of E	Birth	9. Birl	thplace (State	or Foreign
	Funeral Director		Usual Residence of Decedent	48 Yrs.	Months Day	s Hours	8. Date of E Min. (Month, I Sept 9	Day, Year) 9, 19	Co	ountry) `	unk
	and w		10a. State 10b. County 10	c. City, Town or L	Location					10d. Inside (	City Limits
:	Mary ⊢fsh fied	호	MD	Ва	altimore					1 <b>∑</b> Ye	s 2□No
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinat must be notified at	Director	10e. Street and Number		10f. Zip Code			10g. Cit	zen of What Co	ountry?	
	th wit	<u>a</u>	3115 Windsor Avenue		2	1216			USA		
	r dea	Funeral	11. Marital Status unk 12. Was Decedent Ever Armed Forces?	in U.S. 13	3. Was Decedent of If Yes, specify Cu	i Hispanic Or ban, Mexicar	gin? (Specify Ye's or N , Puerto Rican, etc.)	NO-	<ol> <li>Race - Ame Black, White</li> </ol>		
3	or it	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		1 □Yes 2X N				Specify: b	1ack	
200-612	hour tural'	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a Der	cedent's Usual Occ	upation	unl	r 16b. Ki	nd of Business/		unk
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7	d with giene ir tha	E O	Elementary/Secondary (0-12) College (1-4or 5+) unk unk								
2	d d al	Ba	17. Father's Name (First, Middle, Last)		unk	18. Mothe	r's Name (First, Midd	le, Maiden	Surname)		unk
_	2 should be and Menta is marked ( aumatic ev	ြို	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Stre	et and Numb	er or Rural Route Nun	nber, City o	r Town, State,	Zip Code)	unk
2	1 and 2 s Health a em 27 is other trau		Baltimore County Police DEpt	=	,						dir
ָרָ י	es 1 a of Hea fitem rothe		20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other p	lace)	Date	20c. Lo	cation - City or	Town, State	
₹ ,	Page nent c int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Chemother (Specify) in state	oomotory, or	romatory or other p	1					
Daltillole	permit. Pages 1 and 2 should the Department of Health and Men Important: If item 27 is marker any Injury or other traumatic once.		21. Signature of Euneral Service Licensee Ronald S. Wade, Direc	tor S		tomy B	oard 655 W	. Bal	timore	Street	
М			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		Baltimore enter the mode of d			arrest,		Approxima Interval B Onset and	etween
E	To the nospital or Attended in Nasional: The law requires that the death certificate be executed within 24 years within 24 hours after death or attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and to possible the funeral director, page 2 should be detached for use as the burial-transit to be a burial-transit.	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the conditi	phosponsequence of):	ask)	3 di	scase				
. c.	ung rnysician: The law requires that the death certifics After this certificate has been signed by the attending ph funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	3 ☐ Ectopic pregna 5 ☐ Other (specify)			-	23d. Date of de Month	livery Day	Year
	s mar ined b	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the	e underlying cause	given in Part I	23e. Di	d tobacco i	use contribute to	o the cause of	f death?
2	quire:	g p	human immunode	ficie	NCH SH	ndro	me 10	Yes 2	□ No 3 🕱 P	robably 4	Unknown
necolds,	has bee	Completed			ر س		24a. Wa	as an topsy rformad?	24b. Were a prior to death?	utopsy finding completion of	s available f cause of
A I CO	n: In ficate r, paç		05 Was				1 □ Yes	2 1 No	1 □ Yes	2 No	
	sicia certi irecto	Be c	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Impatient	0 T FR/Out	4iam 0 00 0		of Death (Check onl		0	- '6 .)	
5 8	g rny er this eral d	5.	27. Manner of Death 28a. Date of Injury	2 ER/Outpati	e of 28c. In	jury at	ursing Home 5 ☐ Re 28d. Describ			эспу)	
5	th. :: Afte	tiol	1 XNatural 5 ☐ Pending (Month, Day, Ye 2 ☐ Accident investigation	ear) Injury		′ork? □Yes 2□	No				
	or Artel ifter des Director in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	· At home, farm, s Specify)	street, factory, offic	9	28f. Location City or 7	Street ar own, State	nd Number or R	ural Route Nu	umber,
	lo the nospital of Attentwithin 24 hours after deat  To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of m	amination and/or							e(s)
1	ithin 2 the mple	Medical	one) and manner stated  29b. Signature and title of certifier		29c Lice	nse number		29d. Da	te signed (Mon	th, Day, Year)	
ľ	≥ <b>≒</b> ₹ ≅	_	D 1 = M D(1	M	7		770		•		
			30. Name and address of person who completed cause of seath	h (Itam 23a) /Tim	ne Print)	) 2-1	1257	1. (	my A	) 4	001
						Hopk	ns Hospita	2, 3	ay 2	e, MD	2128
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrars  JUN 2 9 2009	S. Jan	Ked	V	A	,		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TEM#4b, C. perPHYS, G892, 6729, 09, we state of Maryland / Department of Health and Mental Hygiene

			1 - For State Of IVIS	aryiand / Depa <i>Cer</i>	tificate of D	Death	R	eg. No. 200	20670
	Physicia	an	1. Decedent's Name (First, Middle, Last)				<ol><li>Date of Deat Month</li></ol>	Day Year	3. Time of Death
****	/Medic	al	Clarkey William Long		4b. City, Town, or I	Location of Death	06	21 2009 4c. County of Dea	14:59
	Examin	er	4a. Facility Name (If not institution, give street and number)	L - 1	Takoma Pa			Montgomer	
al control	Funeral		Washington Adventist Hospi 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		244-14-6445  Usual Residence of Decedent	84 Yrs.	Months Days	Hours Min.	05/1/1	925	SC
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	,	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	e Mai	Director	DC None	Washingto	n				1 X Yes 2 No
	ith th	Dire	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	ountry?
	eath v	Funeral	715 Farraday P1 NE	Ever in U.S. 13.1	20017	enanic Origin? (Sne		USA 14. Race - Am	erican Indian
	ter de ritem	Fun	1 Never Married 2 Married 1 Seyes 2	No	Was Decedent of His f Yes, specify Cubar		Rican, etc.)	Black, Whi	
2-0036	within 72 hours after death with the Marylan giene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	If Ŷes, Give	5/29/1944 1 5/31/1946	1∐Yes 2⊠XNo	Specify:		Specify: B	Lack
2-C	22 Z	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done do			16b. Kind of Business	/Industry
7	filed within 7 I Hygiene. other than "r ent, the Med	шb	Elementary/Secondary (0-12) College (1-4or s	ife. L	DO NOT use retired)			IIC Doobol	Committee
7	e filed wall Hygie other t		17. Father's Name (First, Middle, Last)	s   Clerk		18, Mother's Name		US Postal Maiden Surname)	Service
yland	e d ta	o Be	James Long			Sarah NE		,	
		ြ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a			r, City or Town, State,	Zip Code)
Mar	nd 2 alth a 27 is		Joan Verdier / Grand-daught	er   715 Fa	arraday Pl	l NE Wash	ington	DC 20017	
or e	es 1 al of Hea fitem rothe		20a. Method of Disposition	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	D.	ate	20c. Location - City o	Town, State
Ĕ	. Pages tment of <b>tant: If it</b> <b>jury or o</b>		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ft. Lincol	ln Cemeter	ry 6/29/		Brentwood	
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee					Funeral H	lome
<b>.</b>	w o		g. p. Marshall		217 9th S1			-	Approximate
			23a. Pan 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	ne.	er the mode of dying	g, such as cardiac o	r respiratory an	est,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Pneumon						
	Examiner		Due to (or as	a consequence of): tory Failur	ro				
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	cuted nd ransit	Examine	cause. Enter underlying Cause (Disease or injury that initiated events  c						
Š,	e exe ian al urial-t	Ë	resulting in death) Last Due to (or as	a consequence of):					
8/60	tificate be executed g physician and as the burial-transit	edical	d						
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Ř	death certi e attending d for use a	Physician/N	in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
r Ö	t the c by the ached	hysi	9 ☐ Unknown 9 ☐ Unknown						
	requires that the neen signed by th	by P	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
ğ	equire en siç ould b	ed	<u>Dementia</u>				1 🗆 Y	es 2 No 3 1	Probably 4 🖸 Unknown
<b>Records</b> ,	as b	Completed	H/O Cancers colon, pros	tate, anus			24a. Was a	sv i prior to	autopsy findings available completion of cause of
	Th ate pag	Con					perfor 1 □Yes	med? death? 2⊠No 1□Ye	s 2 🔀 No
VITal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		othe Othe	26. Place of Death			
0	Phys r this ral dir	۲:	1 ☐ Yes 2 ☑ No 1 ☐ I ☑ Inpati 27. Manner of Death 28a. Date of Inj	ent 2 ER/Outpatier	IL 3 LL DOA	4 🗀 Nursing Hor		lence 6 Other (Sp low injury occurred	ecify)
	Attending r death. ector: After by the funer	tion	1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	iy, Year) Injury	Work				
UIVISION	Il or Attendi after death. I Director: A d in by the fu	ifica	3 Suicide 6 Could not be 28e. Place of In	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	- 2	28f. Location (S City or Tow	Street and Number or I	Rural Route Number,
5	s after s after al Dir	Certification:	4 Admicide	c. (Opecny)			City of Yow	ni, Otate)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best 2 ☐ Medical Examiner: On the basis one and manner start.	of examination and/or in					
	orthe	Med	29b. Signature and title of certifier	1 / 1	29c. License	number	- 1	29d. Date signed (Moi	nth, Day, Year)
h	r s r ō			1,001	045 471			5/22/2009	
į			30. Name and address of person who completed cause of	death (Item 23a) (Type,			10	112212007	
(	QV		Yeheyis Negussie 7	600 Carroll	Ave. Ta	ıkoma Parl	, MD 20	0912	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 2 9 2009  Servine  32. Regist	rar's Signature	,				
	1000		COUNTRY OF FULLY ANDREWS	w . / / / / / / / / / / / / / / / / / /					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:30 am Selma Toba Maston 29, 2009 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Linthicum Hospice of the Chesapeake Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Months Hours 1 ☐ M 2 🔀 91 054-07-7699 01/27/1918 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1√2Yes 2□No Glen Burnie MD Anne Arundel Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7939 21061 Elvaton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ZXNo
If Yes, Give
Year or Dates: 11 Marital Status 12 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3altimore, Maryland 21215-0036 Specify. þ 3€Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Petruka Samuel Winter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3609 Marsh Park Court, Jacksonville, FL, 32250 Bruce A. Maston / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 6/29/2009 Hanover, MD 1 Burial 2 Autremation 5 Other (Specify)

21. Signature of Funeral Service Licensee Dorota Marshall

Maryland Cremation Services Maryland Cremation Maryland Maryland Cremation Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21203 Immediate Cause (Final disease or condition resulting in death) **Physician** 20116 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760%Due to (or as a consequence of): physician Physician/Medical the attending ph IF FEMALE: lf yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⋈ nknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 No 1□ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 32 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUN 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 占 Month Day **Physician** 7:25 A M Edward Philip Matthew, Jr. ,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** lame Known to Physician: Matthew, Edward YA Mory and realth Care

5. Social Security Wimber 6. Sex 7. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-80-4190 Maryland 10/27/1959 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f sho event, the Modern Evaniner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 U.S.A. 321 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 120Xes 2 □ No 1976— If Yes, Give Year or Dates: 1979 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIo Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ite Magnes." Elementary/Secondary (0-12) College (1-4or 5+) Utility Contractor 12 Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Jean Parrott Edward Philip Matthew, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 139 West Gay Street, Red Lion, Pa. 17356 Constance Matthew (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Ma Cremation 3 ☐ Removal from State Bayview Crematory, Inc 06/27/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part I. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NSDIratio /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and burial-trar Due to (or as a consequence of) the attending physician pe Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ☐Yes 2 ☐No Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death Il Director: After the in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled Funeral hours triping Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical within 24 P and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. va Maryland Nealth Care System, Perry Point, MO21902 Avelinatherna 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 2 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>D</sup>2009 June 26, 4:40 Рм Myra Julia Moody 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Lutherville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/18/1923 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 25 T 218-18-9323 85 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 813 Platinum Avenue 21221 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White ¥XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Mummert Ira Moesinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Platinum Avenue, Baltimore, Maryland 21221 Johnny Jones (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/29/2009 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Fastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final di ase or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 mopths? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spec 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

sion of Vital Records, P.O. Box 68760 MOON

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: within 24 hours after death

To the Funeral Director: To the Hospital

Completed by Be

Medical

Examine

Physician/Medical Certification: To

**Physician** 

/Medical

Director

Completed by Funeral

Be ပ

**Examiner** 

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show

altimore, Maryland 21215-0036

56,2009

Department of Health and Mental Hygiene. Important: yor Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

/Medical

Examiner

2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

5 ☐ Pending investigation

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and addre

State Registrar 31. Date filed (Month. Day, Year) JUN 29

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Healt Certificate of Dea		Reg.	0000	20674
	Physicia		1. Decedent's Name (First, Middle, Last) Wilbert Oliver	M	ne 21	Day 2009	3. Time of Death 11:38 P M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center  4b. City, Town, or Locat  Annapo			4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Ur Months Days Hou		Pate of Birth Month, Day, Ye 04/18/19	9. Bir 954	thplace (State or Foreign ountry)
	yland now		Usual Residence of Decedent  10a. State				10d. Inside City Limits
	8a-fsh	ector	MD Prince George's Riverdale		10-	Citizen of What Co	1 d Yes 2 No
	h with th	al Dir	10e. Street and Number 10f. Zip Code 20737	7	10g.	USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Madical Evanting must be rediffied at once.	by Funeral Director	11. Marital Status  1 XNever Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 XPes 2 No If Yes, specify Cuban, Message Forces and the Specify Cuban of Specify Cuban, Message Forces and Specify Cuban of Spe		Yes or No- n, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	in 72 ho n "natur Audical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working	16b	. Kind of Business	/industry
212	e filed within al Hygiene. I other than " vent, the Me	Com	Elementary/Secondary (0-12) College (1-4or 5+) Mechanic			Automot	ive
land	ild be fill fental H rked oth ic even	To Be	17. Father's Name (First, Middle, Last)  Brodus Oliver	Mother's Name <i>(Fir</i> s <b>Bertha</b>	Pelzer		
, Maryland	and 2 should ealth and Mer n 27 Is marke ner traumatic	-	19a. Informant's Name/Relationship (Type. Print) Mary Ann Oliver-Ohue / Daughter 218 Johnson Dri				Zip Code)
Baltimore,	Pages 1 at ment of He tant: If item		20a. Method of Disposition  1XI Burial 2 Cremation 3 MR Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Island Cemetery	Date 6/27/20	09	Santee,	SC
Balt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Funeral Service Licensee Dorota Marshall 1501 East E	Stevens i Fort Aveni	Funeral ue, Bal	L Home In Ltimore,	c. MD 21230
	tificate be executed  Wedical Brauminer  Brauminer  As the burial-transit	l Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unicerlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	harde	ion		Approximate Interval Between Onset and Death
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rds, P.	quires than signed and be det	è	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I.			to the cause of death?  Probably 4 Unknown
Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed	Orophanyageal cause		24a. Was an autopsy performed 1 □ Yes 2	d? prior to death?	utopsy findings available completion of cause of
	/sician s certif	o Be	examiner?	Place of Death (Ch ☐ Nursing Home		e 6 ∏Other (So	ecify)
n of	Ing Phy	on: T	27. Manner of Death 28a. Date of Injury at Work? 28b. Time of Injury at Work?	28d.	Describe how		
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  investigation 6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	Location (Stree City or Town, S		Rural Route Number,
_	e Hospital	Medical C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, de and manner stated.	ate and place, and on, death occurred at	due to the cau	se(s) and manner and du	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier  D  29c. License num  D  6	376	29d	Date signed (Mo	Mh, Day, Year)
	lo		30. Name and address of person who completed cause of death (Item 23a) (Type, Mint)	Anna	rolin	CM =	21401
	Sta Registr		31. Date filled (Month, Day, Year)  JUN 2 9 2003	5	4		• • /

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	ryland / [	Departmer <i>Certifica</i>				0.0	200	00075
			Registrar  1. Decedent's Name (First, Middle, Li	aet)		Certifica	te or De	eaur	2. Date of Dea	Reg. No.	JUY	3. Time of Death
	Physicia		George	,	oulak	is			Month	27 Day 20	09	10.50 A-M
~4	/Medic Examin		4a. Facility Name (If not institution, gi	ive street and number)		4b. City	, Town, or Lo	ocation of Death		4c. Count	y of Death	6
A.			Northwest Se	msons Hos	pice			stown		D		MOSE
	Funeral		<ol><li>Social Security Number 6.</li></ol>	Sex 7. Age 1 1 ☑ M 2 ☐ F	(În yrs. last bir	thday) If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 1 – 3 – 1	th v, Year)	Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		69				1-3-1.	740	Gre	ece
	yland how		10a. State 10b. County	1	10c. City, Tow							10d. Inside City Limits
	e Mar 3a-f sl	Director	MD		Balt	imore						1 X Yes 2 No
	/ith th		10e. Street and Number			10f. Zi	p Code			10g. Citizen of	What Cou	intry?
	eath v	Funeral	7103 Boxford R	Road 12. Was Decedent Ev	ver in 11 S	13 Was Dece	212	15 panic Origin? (Spe	ecify Yes or No		J.S.Z	ican Indian,
ω.	r item		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, spe	ecify Cuban,	Mexican, Puerto	Rican, etc.)		ack, White,	
036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evand ver mat be mufflind at	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes	2 <b>X</b> No	Specify:		Spec	ify: Wh:	ite
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	filed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Las	:t)		00110111		8. Mother's Name		Maiden Surna	ıme)	
ılan	uld be Menta rked ric ev	To B	Nikolas	Poulaki	S			Irina	Koulo	cheri		
Maryland	2 short and lisma		19a. Informant's Name/Relationship		195	. Mailing Addres	s (Street and	d Number or Run	al Route Numb	er, City or Tow	n, State, Zi	ip Code)
	1 and 2 Health em 27 i		Diane E. Cohen	- Friend					nore,	20c. Location		21208-3723
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mudbal Event near the nutitied of once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 I			f Disposition (Na ry, crematory or		1			•	
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Ba	permit Depar Impor any in	6 /0	VIIhali	Z		263 5	. Co	nkling	Stree	t Balt	ii 110	id. 21224
			23a. Part 1. Enter the disease or col shock, or heart failure. List onl	nplications that caused the	he death. Do	not enter the mo	de of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between
5	Physician	Ñ	Immediate Cause (Final disease or condition	· Metastat	-	Ion lane	er				2.1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						
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Τ	uted d ansit	Examiner	Sequentially list conditions, if any, leading to finine diatocause. Enter Underlying Cause (Disease or injury	544 (0, 63 3	out and an end							
ó	exec an and rial-tra		that initiated events resulting in death) Last	Due to (or as a	consequence	of):						
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	ertific ding p	Mec	IF FEMALE:	23c. If yes, outcome of	f prognancy			-		001.5		
P.O. Box	eath c attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death	n 3 ☐ Ectopic 5 ☐ Other (s					Date of deli Month	Day Year
o.	the d	ysi	1 □ Yes 2 ☑ No 9 □ Unknown	9 ☐ Unknown		0 🗆 0 1101 (1	<i></i>					
Ϋ́,	ires that the death certificing signed by the attending is be detached for use as	by P	Part II. Other significant conditions	contributing to death but	not resulting i	n the underlying	cause given	in Part I.				the cause of death?
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Zit:	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Deat			m-1	authent hospic
Division of Vital Records,	Phys or this oral dii	Certification: To	1 ☐ Yes 2 ☑ No 27. Mann of Death	28a. Date of Injury	/ 28b.	utpatient 3 🗆 🏻 Time of	28c. Injury a	4 ☐ Nursing Ho		how injury occ		cify)
<u>io</u>	nding ath. r: Afte e fune	atio	1	(Month, Day,	Year)	Injury M	Work? 1 □ Ye	es 2□No				
<u>vis</u>	r Atte er dez recto	tific	3 ☐ Suicide 6 ☐ Could not determine		y - At home, fa	arm, street, facto	ry, office		28f. Location (	Street and Nui wn, State)	mber or Ru	ıral Route Number,
	ital or aft ral Di							4				
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending To the Funeral Director. After this completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the best of aminer: On the basis of and manner state								
	To the within To the Comple	Mec	29b. Signature and title of certifier	and marrier ctar.	<u> </u>	2	9c. License i	number		29d. Date sig	ned (Montl	h, Day, Year)
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			30. Name and address of person wh	o completed cause of deal of the MY 32. legistrar	ath (Item 23a)	(Type, Print)	) (HA	Anielo-	5/21/10	MA	711-	36
			N. S. RAJUPAKSC, 31. Date filed (Month, Day, Year)	VNI) ZS Ma	1/1 Jtg 5	suite e	00	141514	SOWN	,		
	Sta Registr		31. Date filed (Month, Day, Year)	1009 Segistrar	S Gigilatury	parks	/					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ For	State of Maryland	l / Departme	nt of Health and	Mental Hygie	ene	
		1 - State Registrar		Certifica	te of Death	Reg	the tell to the	20676
		1. Decedent's Name (First, Middle, Last)		0		2. Date of DeathMonth	Day Year	3. Time of Death
Physic /Medi		Curley			r	June 2	5 2009	1053 PM
Exami		4a. Facility Name (If not institution, give si			y, Town, or Location of Deat	n	4c. County of Death	
		The Johns Hopkins Hos  5. Social Security Number 6. Sex	7. Age (In yrs. Ia		imore City er 1 Year   If Under 24 Hrs	8. Date of Birth	9. Birthpla	ce (State or Foreign
Funeral Director			M 2 XF M4	Yrs. Months	Days Hours Min.	(Month Day, Ye	43 4 Plantry	
Action 1		Usual Residence of Decedent					100	d. Inside City Limits
arylar shov d at	5	10a. State 10b. County	10e. City,	Town or Location			100	1 ☐ Yes 2 📡 No
the M 28a-f otifie	Director	10e. Street and Number	· Di	enda 1012	ip-Code	10a	. Citizen of What Country	?
with 3a or t be n		103 Center	pl aut 127	}	21222		U.J.A.	
death	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Black, White, etc	
after or ite		1 Never Married 2 Married	1 Yes 2 No		2 No Specify:	io moun, story	Canada Di	,
15-0036 72 hours aft "natural", or edical Exami	d by	3 Widowed 4 Divorced  15. Decedent's Educ	Year or Dates:	16a. Decedent's U	<u> </u>	16	6b. Kind of Business/Indu	ustry
in 72 in 72 in edica	Completed	(Specify only highest grade	completed)	(Give kind of v	vork done during most of wo	orking		,
y with yiene. r thar	I III	Elementary/Secondary (0-12)	College (1-4 or 5+)	Norsa			Health	
aryland 21215-UU36 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Ma	alden Surname)	
Viano yuld be Mental arked o	ည	Percy Miller		T	Gerti	ude to	atterson	
2 a si si		19a. Informant's Name/Relationship (Typ	1	19b. Mailing Addr	ess (Street and Number or F	fural Houte Number,	City or lown, State, 21p C	( 2 2 Z
C = 0 -	١.,	20a, Method of Disposition	e doughter 20b. Pl	ace of Disposition (A	appe hank	Date 20	Oc. Location - City or Tow	n, State
MOF Pages Tent of Int: If it		1 🔀 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		emetery, crematory o	other place)	- 2009 /	Jane, Frun	det led.
<b>Baltimore,</b> permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service License	• 010	22. Hame	and Address of Facility	lesi Funa	4 5	e P.A.
on any per		Carlon (	Doudan	- La	70 McCulla	h St. P	salto. hed.	21217
		23a. Part 1. Enter the disease, or complications, or heart failure. List only one	cations that caused the death.	. Do not enter the m	ode of dying, such as cardi	ac or respiratory arres		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	luna can	cer				Onset and Beauti
/Medical Examiner		resulting in death)	Due to () as a consequ	ience of):				
	ē	Sequentially list conditions, if any leading to immediate	Due to (or as a consequ	ence of):				
ted tnsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	,					
execu n and rial-tra	Ä	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):				
X 68760, certificate be executed ding physician and use as the burial-transit	dical					<u>.</u>		
<b>68</b> artifica	w	IF FEMALE:		-			2124	
Box 68 Jeath certifice attending pt d for use as t	Physician/M	in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopi	c pregnancy		23d. Date of deliver Month	y Day Year
the de y the a	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	au J_Ouloi				
det o	by Pt	Part II. Other significant conditions cor	stributing to death but not resu	ulting in the underlyi	ng cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
Vital Records, ician: The law requires t sertificate has been signe rector, page 2 should be						1 ☐ Yes	2 No 3 Poba	ably 4 🗆 Unknown
aw rec s beer 2 sho	Completed			•		24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
The lav	ĕ					performe 1 Tes 2	ed? death?  1 Yes	2
t VITAL HE la sciolar: The la scertificate has director, page 2	Be	25. Was case referred to medical examiner?	Inneital:		Othori	eath (Check only one)		
Of \Physic Physic this ce trail dire	은	1 Yes 2 No	lospital: 1 Impatient 2 I	ER/Outpatient 3   28b. Time of	DOA Strief 4 Nursing  28c. Injury at	Home 5 ☐ Residen 28d. Describe hov	nce 6 Other (Specify)	
On ding F h. After t	ion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2 ☐ No	200. 200020 110.		
DIVISION OF VITA I or Attending Physician: after death. Director: After this certific d in by the funeral director.	fica	3 Suicide 6 Could not be determined	28e. Place of injury - At hor		ory, office	28f. Location (Street)	eet and Number or Rura	Route Number,
alor safter	Certification:	4   Hollicide	building, etc. (Specify,	)		Ony or rown,		
the Hospital and the Hospital and the Hours and the Funeral Completely filled	edical (	(check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, death occurr tion and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the ca curred at the time, da	luse(s) and manner as st ate and place, and due to	ated. the cause(s)
To the H within 24 To the Fi complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c, License number		d. Date signed (Month, E	
5 × 5 0	-	AAAAA H	Orano )		RES 000		06-25-20	
		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, Print)			00-23-20	
		Adena Greenba		, (-)e-/()	600	North Wolf	e St, Baltimor	e, MD, 21287
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ures bark	W			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year JUNE RUPERT 25 1:19P M ROBERT OWEN 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

FREDERICK

206

FREDERICK

Physician /Medical Examiner

1 - For State Registrar

FREDERICK MEMORIAL HOSPITAL

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirer must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	5. Social Security Number 6. S 213-24-6654	Sex 7. Ag	78 (In yrs. la	st birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Bir Month, Da 12/25/	th 193	ъ	9. Birthpla Counti MD	ace (State or Foreign ry)	
	Usual Residence of Decedent												$\neg$
			10c City	Town or Loc	ation						100	d. Inside City Limits	$\exists$
ō	10a. State 10b. County Carro	11	Toc. Oity,	Mt. A								1 □Yes 2 No	
al Direct	10e. Street and Number 5327 Pommel Dri	.ve	<u> </u>		10f. Zip Code 217	71				S.A.	Vhat Countr	y?	
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 AYes 2 If Yes, Give		1	/as Decedent of Yes, specify Cu □Yes 2⊠N			ecify Yes or No Rican, etc.)	)-		e - America ck, White, et	c.	
egp	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:		16a. Deced	ent's Usual Occ	pation			16b.	Kind of Bu	usiness/Indu		$\dashv$
ple.	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	+)		kind of work don		st of work	ing		C 1 2 c			
5	12	1		Sup	plies S		er'e Nam	e (First, Middle		ilita en Surnam			$\dashv$
lo Be	17. Father's Name (First, Middle, Last Owen E. Rupert	)					Edyt	he V. H	rey	,			
	19a. Informant's Name/Relationship (Bayard Rupert/W		1		g Address <i>(Stre</i> Pomme1							Code)	
	20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	ce	metery, crem	sition (Name of latory or other p			Date 26/2009			City or Tov		
	4 Donation 5 Dother (Special 21. Sign Jure of Funeral Service Lice		//									P2A784	
	23a. Part 1. Enter the disease, or com	pplications that cause	the death.							int1		Approximate Interval Between	
	shock, or heart failure. List only Important Couse (Final disease or ondition regulting of death)	a. META	ATZ		RE	NAL	C	ANC	ER			Onset and Death	J
	Sequentially list conditions,	Due to (or as											
amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dusito (criad	a conseque	ence of):									
cal Ex	resulting in death) Last	Due to (or as	a conseque	ence of):									
큣												_	_
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal	death 3	Ectopic pregna Other (specify)						te of delive	ry Day Year	
y Ph	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the un	nderlying cause	jiven in Part	l.	23e. Did	tobacc	o use con	tribute to th	e cause of death?	
ted by	- CARDIO M	IOPAT	HY			-		1 🗆	Yes	2□ No	3 Prob	ably 4 Unknown	
Complei	- KENAL		JRE					24a. Was auto perf	opsy formed?	?	prior to cor death?	osy findings available npletion of cause of	
Be Co	25. Was case referred to medical	FAIL	JKI			26. Plac	ce of Dea	1 ☐ Yes th (Check only		No	1 □Yes	2 ( <b>X</b> No	
	examiner? 1 ☐ Yes 2 X No	Hospital: 1/1 Inpati		R/Outpatien	t 3 🗆 DOA		lursing H	ome 5 ☐ Res				()	_
ation:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigatio		iry iy, Year)	28b. Time of Injury	l W	jury at ork? □Yes 2□	∃No	28d. Describe	how in	jury occur	red		
Sertific	3 □Suicide 6 □ Could not be determined	28e. Place of in	ury - At hor c. (Specify	me, farm, stre	eet, factory, offic	9		28f. Location City or To	(Street own, St	and Numi ate)	ber or Rura	I Route Number,	
Medical Certification: To	29a. Certifier 1  Certifying P (Check only one) 2  Medical Exa	hysician: To the best miner: On the basis of and manner st	of examinat	vledge, death ion and/or in	n occurred at the vestigation, in m	time, date a	and place eath occu	e, and due to the rred at the time	e cause e, date a	e(s) and mand place,	nanner as s and due to	tated. the cause(s)	
Me	29b. Signature and title of certifier	win h	л D		29c. Lice	nse number	08				ed (Month, I	Day, Year)	}

State

Registrar

400 West 7th Street, Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Florian Rusu 31. Date filed (Month, Day, Year)

JUN 29 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #26 Per Plan 6/29/99 partment of Health and Mental Hygiene

			For State Registrar	Terstatte on wa	ryiand f		ificate of			Reg. N	and the second	2067
	Physici /Medio		1. Decedent's Name <i>(First, Middle</i> <b>Keith</b>	, Last) Alan	Rawl	_				27 <b>,</b> <sup>D</sup>	2009 Year	3. Time of Death 8:00 P
	Examin		4a. Facility Name (If not institution Franklin Square	•			4b. City, Town, o		ath	4	c. County of Death Baltin	ore
	Funeral Director		5. Social Security Number 214 50 1691	6. Sex 7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days			irth ay, Yea 1954	9. Birth Coul Mary	olace (State or Foreig ntry) Land
	iryland show	Ļ	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation				1	0d. Inside City Limit:
	the Ma 28a-f	recto	Maryland Baltin	ore	Esse	X	10f. Zip Code			10g. C	Citizen of What Cou	Λ
	h with 23a or	al Di	1516 Williams A	Avenue			212	21			USA	
الا	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the X7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is investigated as any injury or other traumatic event, It is investigated.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?			as Decedent of H Yes, specify Cub	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh	etc. Lte
Maryland 21215-0036	nin 72 ho 9. In "natul Wedical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4or 5-		6a. Deced (Give k life. D	ent's Usual Occup ind of work done O NOT use retire	oation during most of w d)	vorking	T	Kind of Business/In	•
133 d 213	filed with Hygiene ther tha	Com	12 17. Father's Name (First, Middle, I	<u> </u>		iscal	Managem	ent Ana 18. Mother's N	lysist ame (First, Midd		ninistrat: en Surname)	ion
Aan	Vental Vental rrked o	To Be	Joseph Arthur I					Ma	ry McNea	ve		
_	and 2 sho salth and I n 27 Is ma er trauma	ľ	19a. Informant's Name/Relationsh Barbara Rawleig			1516	Williams	Avenue		Aryl	or Town, State, Zi Land 2122	1
Cott	ages 1 a ent of He it: If Item y or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State			ition (Name of atory or other pla Mem. Ga		Date /30/2009		Location - City or T	own, State  ounty, Md
Kert Baltimore	permit, F Departm Importar any Injur		21. Sgriptur of Funeral Service		110111	22.	Name and Addre	ess of Facility	Bruzdzin	ski	Funeral 1 Marylan	Home PA
			23a. I art . Enter the disease or s ook, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each lin	e.	Do not ente	r the mode of dyi	ng, such as card	liac or respiratory			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease condition resulting in death)	a. Arto Due to (or as a			ic Can	dioves	وسراها؟	Dis	Secse	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequen	cs oly:					- 23	
₽.09289	icate be executed physician and the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequen	ce of):						
_	tificate ng phys as the	ledical		d								
O. Box	leath cer attendir for use	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal de	eath 3	Ectopic pregnan Other (specify)	су			23d. Date of deli Month	very Day Year
ds. P.	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant condition	ons contributing to death bu	ut not resultin	ng in the un	derlying cause gl	ven in Part I.			o use contribute to	the cause of death?
Division of Vital Records. P.O.	The law rec ate has bee age 2 shou	Completed							24a. W au pe	topsy rformed	24b. Were aur prior to co death?	topsy findings availab ompletion of cause o
Vita	Iclan: Dertifica ector, p	Be	25. Was case referred to medical examiner?	Hespital:			I Ot		Death (Check onl	y one)		
of	Physical direction	5	Yes 2 ☐ No 27. Manner of Death	1 ∟1 Inpatie	ry 28	3b. Time of	3 DOA Ot				6 ☐ Other (Special of the following of	sify)
sion	Attending death. ctor: Afte y the fune	cation	1 Natural 5 ☐ Pendin 2 Accident investig 3 ☐ Suicide 6 ☐ Could	gation		Injury	M 1	rk? ]Yes 2 □ No				
Divi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	4 ☐ Homicide determ	ined 286, Place of Influence building, etc					City or	Fown, St		
a	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	29a, Certifier 1 Certifyir (Check only one) Medical	g Physician: To the best Examîner: On the basis o and manner sta	f examination	edge, death n and/or in	occurred at the restigation, in my	time, date and p opinion, death o	lace, and due to occurred at the tin	he caus ne, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifie	MD DEPL	vts		29c. Licen	se number			Date signed (Month	
			30 Name and address of person	who completed cause of d	eath (Item 23	3a) (Type,	11.11	:\\ <t.l< td=""><td>athero:11</td><td>e, N</td><td>Me28,</td><td>13</td></t.l<>	athero:11	e, N	Me28,	13
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	9	ar's Signatur	har	11					
	HMH 17 Pay 1/		LJUN 2 9 2	009 Sentua	/J.	gran						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24 Pay JMNF 2009 **Physician** 10:03 PM TOBY Н ROSEN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10/22/1925 Months Min 1 □ M 2 💢 F 83 216-20-2762 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experiment has be notified at 1 ☐ Yes 2 X No **PIKESVILLE** MD BALTIMORE 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 725 MT. WILSON LANE, #216 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No Specify þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER EDUCATION** 12 should be filed w h and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOLZWEIG IDA SODDEN NATHAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau ELLEN ROSEN / DAUGHTER 1409 MILLBROOK LANE, WYLIE, TX 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/25/2009 BALTIMORE, MD BETH TFILOH CONG. 4 □ Donation 5 □ Other (Specify) 21. Signature of Furneral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Kemi 23 Part 1. Enter the disease, or complications that caused the de rih. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final charl **Physician** Due to (or a consequence of): disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran and Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Month Vear in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) ed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 Probably 4 Unknown 1 TYes cate has been si page 2 should b Completed 24a. Was an autopsy performet 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death

1 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature npleted cause of death (Item 23a) (Type, Print) 30. Name a 10 MON 31. Date filed (Month, Day, Year) State JUN 29 2009 Registrar

09-05025 Henry Shipley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

o, op,		For State Certificate of Death										g. No.	201	19 6	4068
Physician/ Medical Examiner	1.	Decedent's Name (		nlev						Date of Dea Month une 25, 2	Day	Year	3. Time of D 1635 h		
nedical Examine			David Shipley f not institution, give street and number)				4b. City, Town, or Location of Death				uno 20, 2	4c. Cour	4c. County of Death Baltimore		
k	L	University Hospital					r 1 Year	ear If Under 24Hrs. 8. Date of Bir			th (MM/DD/YYYY) 9. Birthplace (State or				
Funeral Director		Social Security Nui 212-50-35	:01	M 2 F	57	st birthday) Yr	Months		Hours	Min.		/1952	Foreig	untry) PA	
any	_	sual Residence of Da. State 16	Decedent Ob. County		10c. City,	Town or Loca	ation							10d. Inside	
<u> </u>		MD.	Carroll	Sy	Sykesville									2 X No	
th the Maryland 23a or 28a-f show notified at once.	10	10e. Street and Number				10f. Zip Code						0g. Citizen o		ntry?	
ith the 23a or notific		1606 Benr 1. Marital Status	nett Road	12. Was Decedent	Ever in U.S	S. 13. W	/as Decede	21784 nt of Hisp	anic Origin	n? (Speci	ify Yes or No		Race - Amer	ican Indian, E	Black,
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year				X No			y Cuban, Mexican, Puerto Rican, etc.)  X No specify:			white, etc.  Specify: White			
hours aftural"  Examine	<u>`</u>  -	15. Decedent's Edu		or Dates: ly highest grade con	npleted)	16a. Decede	ent's Usual most of wor	Occupation	on (Give ki DO NOT u	nd of wor se retired	k done	16b. Kind o	of Business/	Industry	
5-0036 ed within 72 hour tygene. other than "natt the Medical Exat		Elementary/Secon	dary (0-12)	College (1-4 or	5+)	Nurs		Ü				Me	dical		
5-00, ed with tygiene other t	1	7. Father's Name (F						1				Maiden Surn	ame)		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than it event, the Medica	3	George 9a. Informant's Nan	F. Ship.			I 10h Mail	ina Address	Street			E. For	d mber, City or	Town, Stat	e, Zip Code)	
e, MD 21215-003. I and 2 should be filed with Health and Mental Hygiene item 27 is marked other the transmatic event, the Mec To Be Com		Joyce M.										e, MD.			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygene. Iant: If item 27 is marked other than or other traumatic event, the Medical To Be Comple	2	0a. Method of Disp	osition	Removal from St		Place of Disp crematory or	osition (Nar other place	me of cem )	1		Date		-	r Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Specify	<u> </u>	S.	Carro			-		26/200		field		
Baltimore permit. Pages 1 Department of 1 Important: If		MANA	eral Service Lice	41 1 NN			Name and 212 W	r-Ou Vest	Sen I	Tuner Liber	al Ho	me & C ad, Wi	remat nfiel	ary MD.	21784
Physician Medical	16	73a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, door do caused the death. Do not enter the mode of dying, door do caused the death.  Between Onset and Death													
xaminer	1	Imm_dist_Cause (Final disease or condition resulting in death)  a. Confact Gunsnot Wound of Head  Due to (or as a consequence of):													
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
ed nisit		cause. Enter Under Disease or injury th													
uted nd ransit		events resulting in death) Last  Due to (or as a consequence of).  d.													
760, crate be executed physician and the burial - transit	Medical	UNPENDED		AMENDED											
ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transition of the control of the cont	- 12	F FEMALE: 3b. Was decedent past 12 months	?	23c. If yes, outco		2	Fetal death		Ectopic	pregnan	су		eate of delive onth	ery Day	Year
Boy ne death	21	1 Yes 2 N		9 Unknown	the hout made	reculting in th			iven in Pa	ert I	23e. Dio	tobacco use	contribute	to the cause	of death?
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ecor he law te has l ige 2 sh	Ē										pe	rformed? s 2 ✓ No	death?		2 No
al Rian: T	۲ ا	25. Was case referred to medical													
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Division of Vital Records, P.O pital or Attending Physician: The law requires that towns after death.  Filled in by the funeral director, page 2 should be detacted in the funeral director.	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) Single Family (Specific)							or Town, Sta				reet and Number or Rural Route Number, City ate) Road, Sykesville, MD		
y fill bou	<u>ن</u> ا	4 Homicide determined (Specify) Single Family  29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Specify) Single Family  1606 Bennett Road, Sykesville, MD													
To the within 2 To the complet	က္က L	one) 2 🗸		and manner state	d				se number					Month, Day,	
		1/1/	home	ME	<del>)</del>			O.C.	M.E.			June	26, 2009		<u></u>
0	f	(		completed cause o			1 Penn S	Street !	Saltimor	e MD	21201				
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Registr	-11		111111 7 7 7	1111VI   ( M/NV"	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 6:30P 2009 June 22 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Α HOSPITAL T, AGMES If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign South Caroline) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Min Months Days Hours 1 M 2 XF Yrs andluca Director 0 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 Yes 2 No ns 23a or 28a-f sh must be notified Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married o, 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0,12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wado bnee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 10,110, MD. 2,1234 8 a monique 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 ☐ Removal from State -10 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Licenses Balto my 2/22 au wallice Nancy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death bilateral intarcts and cerebral 2 days Multiple Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pneumonia aspiration Shock and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examiner law requires that the death certificate be executed acunar and use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 ☐ Pregnant at time of death signed by the a 9□Unknown 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 2□ No 1 🗌 Yes ica e has t een siç , p-ge 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed' he certificale 2 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient Medical Certification: To this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Date of Injury After (Month, Day Year) 1 Natural 5 Pending Injury 1 TYes 2 🗌 No investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0056143 hus 30. Name and address the person who completed cause of death (Item 23a) (Type, Print) 900, BALTIMORE CATON AVENUE , WIRAYMOND 2HU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June Vear Shankle 2009 2128 M 24 James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In vrs. last birthday) Months Days 1 🗙 M 2 🗆 F 216-22-7718 83 Nov. 21, 1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 Yes 2 No MD Frederick Woodsboro 10g. Citizen of What Country? 10e. Street and Number 10f, Zip-Code U.S.A. 10345 Woodsboro Rd. 21798 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1943–46 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) biomedical research 12 engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Minnie Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) June B. Shankle - wife 10345 Woodsboro Rd., Woodsboro, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Hill Cemetery 6/29/2009 Woodsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lice 404 S. Main St., Woodsboro, MD 21798 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Physician:

l or Attending P ; after death. | Director: After f

To the Hospital within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

**Examiner** 

**Funeral** 

**Director** 

ral", or items 23a or 28a-f show Examiner must be notified at

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

traumatic event, the Medical

Director

Funeral

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and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit attending physician I for use as the buris funeral completely filled in by the

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	Immediate Cause (Final disease or condition resulting in death)	a. lactic ac	idosis			Onact and Board
Completed by Physician/Medical Examiner	Sequentially list conditions, in any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ISCHEMIC  Date to (or as a consequence)  d.	bowel			
ıysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1	I death 3 - Ectopi	c pregnancy (specify)		23d. Date of delivery  Month Day Year
ed by Ph	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlyir	ng cause given in Part I.		co use contribute to the cause of death?  2  7
omplet					24a. Was an autopsy performed'	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ ₩0
BeC	25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 Nursing F	lome 5 Aesidence	6 ☐ Other (Specify)
Medical Certification: To	27. Mannes of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2 No	28d. Describe how in	
ertifica	3 Suicide 6 Could not be determined		me, farm, street, fact /)	ory, office	28f. Location (Street City or Town, Sta	t and Number or Rural Route Number, ate)
dical (		nysician: To the best of my know miner: On the basis of examinat and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier		. 2	9c. License number	29d.	Date signed (Month, Day, Year)
	Matthew hotel	et Vouva		RES - 000	0	6-24-2009

State Registrar

Matthew Robert 31. Date filed (Month, Day, Year) Registrar's Signature knews

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 24 2009 DOROTHY SOLOMON 6:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 09/15/1916 9. Birthplace (State or Foreign Country) RUSSIA 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🕇 F Days Hours 92 109-01-5860 **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show 10a. State r than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director MD N/A BALTIMORE with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3211 CLARKS LANE, #407 21215 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify ₫ Specify 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, trawa any Injury or other traumatic event, trawa ones. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MENDEL ROTHMAN **EDITH** ZINNMAN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY BOWERS / DAUGHTER 12 ESTATES COURT, APT. 5410, BALTIMORE, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State BETH MOSES CEMETERY: 06/26/2009 PINELAWN, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Juneral Service Livinse 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Unnu Centreson disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of). Exami burial-transi P.O. Box 68760, ₹ and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, g 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 | Yes 2 | 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and addless of person with of death (Item 23a) (Type, Print) (eman 31. Date filed (Month, Day, Year) 32 istrar's Signature State Registrar

		For State Registrar	State of M	aryland / I		tment of Hea ficate of De			giene Reg. No. 20	09 2068
Physicia /Medic		1. Decedent's Name (First, Middle,		idy San	ders			2. Date of De	Day	Ye ar 2 209 12 20 P M
Examin	er	4a. Facility Name (If not institution, single Hospital)  5. Social Security Number 6	al of B	al HIMORE ge (In yrs. last bi	rthday)		NORE ( Under 24 Hrs.	8. Date of Birt	4c. County	y of Death  N/A  9. Birthplace (State or Foreig Country)
Director		214-84-8301 Usual Residence of Decedent	1 □ <b>X</b> M 2 □ F	44	Yrs.	Months Days H	lours Min.		, 1964	Maryland
yland how		10a. State 10b. County		10c. City, Tow	n or Local	ion				10d. Inside City Limits
ne Mar 8a-f sl	Director		altimore			Owing	s Mills			1 🕱 Yes 2 🗆 No
with the		10e. Street and Number	,			10f. Zip Code	24447		10g. Citizen of	U.S.A.
death	Funeral	3414 Associated Way  11. Marital Status	12. Was Decedent Armed Forces?		13. Wa	s Decedent of Hispares, specify Cuban, M	21117 nic Origin? (Sp	ecify Yes or No		ce - American Indian,
bre, Intaryland ZIZID-UU30 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. of Health and Mental Hyglene. the marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examination to the conflict at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced					pecify:	Thours, etc.)	Specia	
72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	(Give kir	nt's Usual Occupation and of work done durin		ing	16b. Kind of B	Business/Industry
A I A I D-UUS dene. er than "natural", , the Medic I Evan	duc	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	NOT use retired) Fort Lift C	nerator		Pi	ivate Company
e filed al Hygi other	Be C	17. Father's Name (First, Middle, La	nst)	1				e (First, Middle,	Maiden Surnai	me)
VICIO Suld be Menta arked aric ev	TO E	Fran	k Sanders					Jear	lean Sand	lers
Maryland that Should be file that and Mental Hy to smarked othe traumatic event		19a. Informant's Name/Relationship	(Type. Print)	198		Address (Street and				
re, n s 1 and f Health flem 27 other to		Jearlean Sanders  20a. Method of Disposition		20b. Place of	f Dispositi	4 Associated \ on (Name of		Date		- City or Town, State
partitione, permit. Pages 1 ar Department of Hec Important: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	cemete		ory`or other place) Crematory, Inc	,	06/26/09	Cato	onsville, Maryland
Dalti Departi Departi Importa any inju		21. Signature of Funeral Service Lin  23a Part 1. Enter the disease, or coshock, or hear failure. List or	censee		22.1	lame and Address of	f Facility			
Physician / Medical Examiner  bulk physician and bulk physician and stree prival-transit street privals.	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Se ventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence a consequence a consequence	of): Oi):	hemorr	nage			X AUS
ath certif	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  ☐ Fetal deatl at time of death		ictopic pregnancy Other (specify)			1	ate of delivery Ionth Day Year
	þ	Part II. Other significant conditions  HUDENTENSIO	_	out not resulting i	n the unde	erlying cause given in	n Part I.			ntribute to the cause of death?  3 Probably 4 Unknow
The ate h	Completed	OS Mas accounts and	· · · · · · · · · · · · · · · · · · ·					1 □ Yes	osy rmed? 2 Mo	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/O	utpatient	Other:		th <i>(Check only c</i> ome 5 ☐ Resi		ther (Specify)
nding Phys th. : After this s funeral di	ition: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	28c. Injury at Work?	2 🗆 No		how injury occu	
Il or Attending Phy after death. I Director: After this d in by the funeral di	Certification:	3 Suicide 6 Could not determine	ad   28e. Place of in	jury - At home, fa tc. <i>(Specify)</i>	arm, street	, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical C	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best caminer: On the basis of and manner st	of examination a	e, death o	ccurred at the time, ostigation, in my opinion	date and place on, death occu	, and due to the rred at the time,	cause(s) and r date and place	manner as stated. , and due to the cause(s)
To the comp	Me	29b. Signature and title of certifier	1/11			29c. License nu	mber		29d. Date sign	ed (Month, Day, Year)
		, and M	Colgen N	1D		IRES-	-000		June	23,2009
F		30. Name and address of person wh	no completed cause of a	death (Item 23a)	(Type, Pri	nt)	0/1/10	A00		5 5
Stat Registra		31. Date filed (Month, Day, Year)	32/Regist	rar's Signature	Lacr	RES-	rui Fyi ¥[	OPCI		

Patient Known as Buddy Sanders

		1- For Amend Items 29date 1- Registrar	of Maryland	2 Dop Cer	<b>29709</b> dd tificate o	<b>b</b> Health ai f <i>Death</i>	nd Mental H	lygiene Reg. No	e 2009	2068
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     MURRAY MICHAEL TARLTC      4a. Facility Name (If not institution, give street and	I number)			, or Location of		NE 1	y Year 4 2009 County of Death	
Funeral Director		HEART HOME ASSISTED I  5. Social Security Number 216~10~7340  Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Ye Months Day			Birth Day, Year) <b>y</b> 6,		pplace (State or Foreign RYLAND
eath with the Maryland s 23a or 28a-f show mat be retified at	eral Director	Maryland Baltimore  10e. Street and Number  8800 Walther Blvd. Apt		Town or Loc	Balt:	234	-	ับ	itizen of What Cou	
filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be rediffed at	Completed by Funeral	Arme  1 Never Married 2 Married 1 Married 1 Married 1 Married 2 Married 1 Ma	d Forces? es 2 □ No WW1 , Give or Dates:	16a. Deced	l ∐Yes 2 🔥 I	lo Specify: cupation ne during most of	n? (Specify Yes or Puerto Rican, etc.) of working	16b. F	Black, White Specify: Wh	, etc. ite
uld be filed v Mental Hygid arked other artic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Murray Michael Tarlton				18. Mother	s Name (First, Midd e Antoine	tte	Mordecai	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages that 2 should be filed within 72 hours after death with the Mariah Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examin or must be retified at once.		19a. Informant's Name/Relationship (Type. Print) Virginia A. Tarlton (W:  20a. Method of Disposition  XIX Burial 2 □ Cremation 3 □ Removal ft 4 □ Donation 5 □ Other (Specify)  21. Steparture of Funeral Service Licensee	20b. Pla	8800 ace of Dispo metery, cren kwood	Walthe sition (Name or natory or other Cemete Cameta Name and Ac	Blvd.	Date 6-18-2009 al Home	5 Bal	timore, _ocation - City or altimore,	Md. 21234  Fown, State  Md.
Physician / /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	nat caused the death on each line e to (or as a consequent to (or as	ence of):			d. Baltin ardiac or respirator		Md. 212	Approximate Interval Between Onset and Death
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stcian: The law requires that the discertificate has been signed by the lirector, page 2 should be detached	Completed by						24a. V	Yes  Vas an autopsy erformed?	24b. Were au prior to death?	robably 4 Unknown utopsy findings available completion of cause of c 2 UNo
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To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one)  14 Certifying Physician: T  2 Medical Examiner: On and  29b. Signature and title of certifier	to the best of my know the basis of examinat manner stated.	tion and/or ir	nvestigation, in	ny opinion, dea ense number	th occurred at the ti	me, date a	and place, and due  Date signed (Moni	s stated. e to the cause(s)
Sta Registr		30. Name and address of person who completed  A G G M  31. Date filed (Month, Day, Year)	cause of death (Item	23a) (Type,	Print)	Bulto	. 11W 2	20 20	o k	

Amend 19b. per INf. g892 6.30/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 10b&c. & 10e&f per FH G893 7/6/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 3 = 30 PM TURNER June 22. 2009 KATHERINE CLEMSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel County BALTIMORE-WASHINGTON MEDICAL CENTER Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 85 Oct\_3. 1923 Maryland 579**-**46-8385 Usual Residence of Decedent St. Mary's County 10c. City, Town or Location
Piney Point 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Columbia Maryland Howard County 10g. Citizen of What Country? 10e Street and Number b Pot Lane 10f Zip Code 20674 USA 7432 A Sweet Clover <del>21045</del> 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Gray Charles Orlando Clemson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sweet Clover, Columbia, Maryland 21045
(Name of Date 20c. Location - City or Town, State Katie Turner (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 6/25/2009 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Copede

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21 21 2 pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarc tion Myocardial Due to (or as a consequence of): hour Huzertension S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. neumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ms 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examinar manone.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

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Certification: To

Medical

Benjamin Lee, MD 700 Geipe Road, Suite 204, Catonsville, MD 21228

State
Registrar

Benjamin Lee, MD 700 Geipe Road, Suite 204, Catonsville, MD 21228

31. Date filed (Month, Day, Year)

32. Registrar's Signature

32. Registrar's Signature

33. Date filed (Month, Day, Year)

34. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

052544

June 23, 2009

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2544 illian Mather Thomas 2009 Intola 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore 2andall stown Seasons Hospice @ Northwest 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 05 21 192 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 **X**,F 82 261.54.8817 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 XNo Dade Miami 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11th Avenue Northwest 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Macon Theota Mather ucille 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrea Daughter Bomes Boulevard 7002 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/08/09 Barton, FL 4 □ Donation 5 □ Other (Specify) Joughn C. Greene Funoral svo 22. Name and Address of Facility 21. Signature of Funeral Service Licensee lau Kall Randallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Corobyovascular Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 M No 5 Other (specify) g [] Unknown g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ 2 No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

**Physician** /Medical Examiner Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Marical Exemples in ast two natified at

1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or itel

Maryland 21215-0036

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P.O.

Division of Vital Records.

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Physician/Medical ş Completed Be Certification: To After this

funeral 24 hours after death. ■ Funeral Director: A the filled in by

Medical completely within 2 State

25. Was case referred to medical examiner? 1∐ Yes 2∭ANo

29a. Certifier

(Check only one)

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

6 □Could not be 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and title of certified

29c. License number 1445931 29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 33a) (Type Print) Horris Baltimore MD Eburah

Registrar

31. Date filed (Month, Day, Year) **JUN 29** 

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_			2021 Oak 5. Social Security Number	6. Sex	7 Age (In vrs	. last birthday)	If Under 1 Year	TIF Under 24 Hrs	8 Date of Birth	1	9. Birth	place (State o	r Foreign
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Kr	1)		29b. Signature and title of certifier  30. Name and address of person of the control of the cont	who completed cau	ise of death (Ite	em 23a) (Type,	Print)	GUTAT i).	- LINT	THCH	u, n	1	
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			1- For Amend Items 28a-for Maryland / I	Department of Certificate of	lealth and M <b>09dhb</b> Death	lental Hyg	jiene <sub>eg. No.</sub> 200	9 20689
			Decedent's Name (First, Middle, Last)			Date of Dear     Month		3. Time of Death
	Physicia /Medic		Myron Wiggins			May 31		10:06 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	1	Location of Death		4c. County of D	
and the			6120 Edmondson Avenue, Apt. 5	Catonsv		0 D 1 ( D) 14	Baltimo	
	Funeral		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	; Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent			3/14/19	162   50	outh Carolina
puely	MOL TE		10a. State 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits
M	a-f st	ctor	MD Baltimore Cator	nsville				1 □Yes 2X No
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ind 21215-0036 he filed within 72 hours after death with the Maryland	Ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner in test be notified at	Funeral Director	6120 Edmondson Avenue, Apt. 5	21228			USA	
r G	teas	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, /hite, etc.
36	lo.	by F	1 ★Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 □Yes 2X No	Specify:		Specify:	Black
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Baltimore,	Department of H Important: If ite any Injury or ot once.		21. St nature of Funeral Service Excensee	22. Name and Addre	ss of Facility Hu	obard Fu	neral Hor	me, Inc.
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	ng ph as th	/led	TE SERVICE AND A					
BOX	attending p	an/h	IF FEMALE:   23b. If yes, outcome of pregnancy  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death	n 3 ☐ Ectopic pregnanc	v	MA	23d. Date of	
O. Box 68/60, the death certificate be executed	the at ned fo	hysician/Me	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   9   Unknown   9   Unknown	5 Other (specify)	,		Month	Day Year
J		Phy	Part II. Other significant conditions contributing to death but not resulting i	n the underlying eause give	on in Part I	23a Did to	hacco use contribu	te to the cause of death?
Ords, P	signe I be c	by	Hepanin's C VIRUS	in the underlying cause giv	on in raiti.			Probably 4 Unknown
	been	etec	ALCOHOL ABUSE			1		
I Mecords, The law requires to	S 88	ompleted by	HUMAN IMMUNDOFFICIENCY	VIRUS		24a. Was a autop: perfor	sy prior med? deat	re autopsy findings available r to completion of cause of th?
	ificate or, pa	e Co	25. Was case referred to medical		00 Di of D	1 □ Yes		Yes 2 □No
Sicia	s cert	o Be	examiner?  1 Yes 2 KNo Hospital: 1 Inpatient 2 ER/O	utnationt all Dog Oth	er: 4 \( \text{Nursing Ho} \)		ence 6 Other (	(Specific)
9 9	er thi	$\vdash$	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injur			ow injury occurred	Ореску)
	ath. r: Aft ie fun	atio	1 Natural 5 Pending (Manth, Day, Year) 2 Accident investigation 5/3//9		Yes 2 KNe		A PA	
<b>DIVISION</b> I or Attending	recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	11-00		28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Number,
<u>ੂੰ</u> ਟ	rrs aff	Ser		HONE, NO 17	7007		שאט	<del>00011</del>
Hosp	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  2□ Medical Examiner: On the best of my knowledg the control of the properties of examination and manner stated.	e, death occurred at the ti nd/or investigation, in my o	me, date and place, ppinion, death occur	and due to the or red at the time, or	cause(s) and manne date and place, and	er as stated. due to the cause(s)
o the	vithin o the	Med	29b. Signature and title of certifier	29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
<b>—</b>	> ~ 0		1600	l Do	006654	<i>Y</i>	6/1	109
			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) 12.3	006654<		~FST.	/
			KEVIN L. CAM, MD	RA	THORE	mo	21202	
	Sta		31. Date filed (Month, Day, Year)  JUN 2 9 2009  32. Registrar's Signature	arkel		,		
	Registr	ar	JUN & J ZUUS CAMPO P. 19	V-17 (2.7)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 20<u>09</u> Month **Physician** 5:55 P™ June 26 WILLIAM JACOB WIESAND, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER AT GBMC Baltimore County Towson 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 91 Director 213**-**12-0323 April 28, 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination and be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore County Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 706 Stoneleigh Road 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Construction vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Louise ပ K. Voelgel William Jacob Wiesand, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Stoneleigh Road, Baltimore, Maryland 21212 <u>Margaret M. Wiesand</u> (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Parkville, Maryland 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 21. Signature of Funeral Service Consee Martin D. Lawson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MARKINGON ENS discose /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 1 Yes 2 1940 certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSPI Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D g 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar DHMH 17 Rev 1/2001

MY

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAR

29b. Signature and title of certifier

AMON

31. Date filed (Month, Day

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

Charles ST Tonson MO)

State of Maryland / Department of Health and Mental Hygiene... Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Alma Weller June 19 2009 3:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing & Rehab. Carroll Taneytown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 26, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F Maryland Director 214-16-1836 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modest Examinat must be notified at 1 ☐ Yes 2 XNo Directo Union Bridge Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 433 Clear Ridge Rd. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) 11 owner/operator launderette 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Ments item 27 is marked Clarence A. Porter Esther Dudley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert W. Weller/ son 1944 John Shirk Rd. Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Pipe Creek Cemetery 6/22/2009 4 ☐ Donation 5 ☐ Other (Specify) nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service 6 E. Broadway UnionBridge, MD 21791 ner 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ANo 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2. To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name an address of person who comple 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH G892.6/29/09 WS
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 10:00 AM 17, 2009 Woods, Sr. June Bernard Paul /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Northampton Manor Nursing Center Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 X M 2 □ F 29,1920 Maryland 214-12-3265 **Director** Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1XYes 2 □ No Director MD Frederick Walkersville 10g. Citizen of What Country? 10e. Street and Number U.S.A. 215 Cramer Ave. 21793 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, It o Medical Examiner must once. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) painter contract painting 12 18. Mother's Name (First, Middle, Maiden Surname) **Knatz** 17. Father's Name (First, Middle, Last) Be Bernard Thomas Woods Jane <del>Cnatz</del> ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 215 Cramer Ave., Walkersville, MD 21793 B. Paul Woods Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 6/23/2009 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Sign of Funeral Service License atharia Woodsboro, MD 21798 404 S. Main St., 23a. Part 1. Enter the disease, or complications that a death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Cause (Finel **Physician** Due to (or es a desequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine executed and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 No Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en 1 □Yes 2 No 1 ☐Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Hiren Shah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

homas /ho

09-04963 Daniya Webb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

alliya vvebb		- For State C6	ertificate of Death	Reg. No.	200	9 2069
Physici	_	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Day	Year	Time of Death
edical Exami		Daniya Webb		June 23, 2009		1727 hrs
		4a. Facility Name (if not institution, give street and number) Harbor Hospital Center	4b. City, Town, or Location of Death  Baltimore	1 40	c. County of Death	
			last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(MM)	/DD/YYYY) 9. Birth	place (State or
Funeral Director			Months Days Hours Min		Foreign	ntry) MD
<b>D</b> 1100107	-	215 77 9339 1 M 2 F Usual Residence of Decedent	2 Yrs.	100.30,	2000	· MD
any	ŀ		ty, Town or Location		1	10d. Inside City Limits
<b>*</b> .	_	MD n/a	Baltimore			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g. Cit	izen of What Count	ry?
vith the Maryland s 23a or 28a-f show s notified at once.	늅	2822 Carver Rd	21225		USA	
215-0036 be filed within 72 hours after death with the Maryland mall Hygiens hand the death other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	eral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (S	specify Yes or No-	14. Race - America White, etc.	an Indian, Black,
death or ite	Funeral	X Never Married 2 Married 1 Yes 2X No		, , , , , , , , , , , , , , , , , , , ,		,
s after ral", niner	<u>a</u>	Widowed 4 Divorced If Yes, Give Year or Dates     Decedent's Education (Specify only highest grade completed)	1 Yes 2 XNo specify:  16a. Decedent's Usual Occupation (Give kind of	work done 16h	Specify: blace Kind of Business/In	
hour "natu	ţę.	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ref		, , , , , , , , , , , , , , , , , , , ,	,
36 hin 72 than '	ple	n/a	n/a		n/a	
5-00 ed wit ygien other he Ma	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Maider		-
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Hanif Webb		Tyreesia		
D 21 should and Me 7 is ma	안	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or	Rural Route Number, (	City or Town, State,	Zip Code)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygies and matter after a marked other than "natural"; or other traumatic event, the Medical Examine:		Tyreesia Johns /mother	2822 Carver Rd E	Balto,Md. Date 20c	21225 Location - City or 1	Town State
of Hear Ir		4 Division 2 Commettee 2 Removed from State	crematory or other place)			· =
imC Page ment tant: or of		4 Donation 5 Other Specify:	ic. Sion cemerery	uly 1,200	9 Balto	, Ma .
Baltimore, permit. Pages I at Department of He Important. If ite injury or other tr		21. An ature of Funeral Service License	22. Name and Address of Facility Calvin B. Scrug	gs Funer	al Home	
Physician		23a. Part I. Enter the disease, or complications that caused the de-	ath. Do not enter the mode of dying, such as cardiac	or respiratory arrest, st	1 to Md.	21212 Interval
/Medical	3 3	failure. List only one cause on each line.				Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hemoperitoneum  Due to (or as a consequence	e of):			
		Sequentially list conditions, b. Hepatic Tumor				
	ine	if any, leading to immediate cause. Enter Underlying Cause				
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last	e of):			
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0, be ex sician	Medical	UNFERDED -			2d Date of deliver	
876 ificate ig phy is the l		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the	regnancy  2 Fetal death 3 Ectopic pregi		3d. Date of delivery  Month E	ay Year
Sox 687 leath certific e attending p	icia	past 12 months?  4 Pregnant at time of				
Bo le deal the al	Physician/	1 Yes 2 V No 9 Unknown 9 Unknown		220 Did tobaco	o uso contribute to	the cause of death?
, P.O. B ires that the d signed by the		Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in Part I.			ably 4 Unknown
ords, F w requires as been sign should be	Completed by	·		- [ 24a. Was an	24b. Were au	topsy findings available
COLC law re has be 2 sho	l dc			autopsy performed		completion of cause of
tal Rec inn: The certificate	5				No 1 Y	es 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner? Hospital: 4 Inpatient 2	26.Place of Death (Chec ✓ ER/Outpatient 3 DOA Other Nurs		dence 6 Other	······································
f Vi Physi er this	-	1 ✓ Yes 2 No Impaterit 2  27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how i		·
on of nding Pl th.	ioi	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
vision of vortision of the death.  Director: After tine by the funeral	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	At home, farm, street, factory, office building, etc.			ral Route Number, City
Division ospital or Attenchours after death meral Director:	Certification:	Suicide 6 Could not be determined (Specify)		or Town, State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of my know	rledge, death occurred at the time, date and place, a	nd due to the cause(s)	and manner as stat	ed.
To the Ho within 24 } To the Fu completely	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.				
	ž	29b. Signature and title of certifier	29c. License number		d. Date signed <i>(M</i> o une 24, 2009	пш, µау, үеаг)
		Carol Hullan	O.C.M.E.	30	JITE 24, 2009	
•		30. Name and address of person who completed cause of death (I Carol Allan, MD Assistant Medical Examiner		201		
- 5	tate	IIIN 9 6 2000	10 Marke			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #5, per FH 8893 7 / //09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2:58P M Daniel Ernest Zile June 2009 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll Birthplace (State or Foreign Country) 5. Social Security Number 218 - 32 - 5296 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funera: 7. Age (In yrs. last birthday) Months Days Hours 1 XM 2 ☐ F 72 Yrs. 30,1936 Director Dec. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Evandara must be notified at 1X Yes 2 No Director MD Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 S. Benedum St. 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 XNo Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 filed within Hygiene. College (1-4or 5+) d 2 should be filed with and Mental Hygier 7 is marked other th shipping clerk cement company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Haven Zile Catherine Bentz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important; If item 27 is any Injury or other traus Pat Zile - wife 15 S. Benedum St., Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 6/27/2009 | Union Bridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem. 22. Name end Address of Facility Hartzler Funeral Home of Foneral Service L 6 E. Broadway, Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute MI 1 hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CAD 10 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed DM 20 yrs. attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) signed by the ad be detached to P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð icate has been si r, page 2 should b Chronic Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ØNo certificate 2 🗆 No Division of Vital 1 Tyes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💆 DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 ☐ Accident Injury 5 Pending 124 hours after death.

le Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. within 2. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0020330 June 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John M. Lehigh, 104 N. Main St., Union Bridge, MD 21791 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 2 9 2009

		Please  1 - For State Registrar	State of Ma		d / Depa		Health and			)	2000
Physicia /Medica		Decedent's Name (First, Middle, L Frank	Mason			Artz		2. Date of De Month <b>June</b>	eath 18	<sup>y</sup> 2009	3. Time of Death 7:13 A M
Examine Funeral Director	er	4a. Facility Name (If not institution, g 17734 Rench Roa 5. Social Security Number 217–28–6633	d	e (In yrs. I	ast birthday) Yrs.			rs. 8. Date of Bi	rth ay, Year)	Co	
Maryland Fired at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Washing	ton	10c. City	y, Town or Lo				,		10d. Inside City Limits 1 □Yes 2 □ No
fler death w	Funeral Director	10e. Street and Number  17734 Rench Road  11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 □ Yes 2 ∑ N	Ever in U.:	S. 13.	10f. Zip Code 21740	Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No		U.S.A.  14. Race - Amel Black, White	rican Indian,
within 72 hours iene. than "natural", the Medical Exa	Completed by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest g  Elementary/Secondary (0-12) 12	If Yes, Give Year or Dates: Education rade completed)  College (1-4or 5	+)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation	working		Specify: Whating of Business/I	•
should be filed vand Mental Hygie s marked other I umatic event, in	To Be Co	17. Father's Name (First, Middle, Las Howard M. Artz 19a. Informant's Name/Relationship					Cathe	Name (First, Middle rine Brev Rural Route Numb	, Maider Ver	Surname)	
Pages 1 and 2 s nent of Health ar int: If item 27 is iry or other trau		Sally L. Artz/Wi  20a. Method of Disposition  1  Burial 2 Cremation 3   4 Donation 5 Other (Spec	fe ☐Removal from State	1	17734 lace of Dispo emetery, crei		Road, Ha	gerstown; Date 22/2009	20c. L	21740 ocation - City or gerstown	Town, State
permit. Departr Importe any Inju		21. Signature of Funeral Service Lice  23a. Part 1. Enter the disease, or conshock, or heart failure. List only	nplications hat caused	the death	1		sylvania	Rest Have A Ave., H	lager		
bur icia	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	a consequ	uence of):	anco					Onset and Death
the death certificate by the attending physiched for use as the t	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	☐ Ectopic pregnan☐ Other (specify)	су			23d. Date of del Month	ivery D <i>a</i> y Year
igne bed	2	Part II. Other significant conditions	contributing to death be	ıt not resu	Ilting in the u	nderlying cause gi	ven in Part I.		Yes 2	! □ No 3 □ Pr	the cause of death?  obably 4 Unknow
sician: The law rector, page 2 sh	Be Completed	25. Was case referred to medical examiner?				1		- auto	opsy ormed?	prior to death?	completion of cause of
ding Phy. h. After this funeral di	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide	28a. Date of Inju (Month, Da	ry v, Year) iry - At ho	28b. Time o Injury	of 28c. Inju		g Home 5 🔀 Res 28d. Describe 28f. Location City or To	how inju	iry occurred	cify) ural Route Number,
To the Hospital or Attenwithin 24 hours after dealt To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  29 Medical Extended the control of the certifier  29 Medical Extended the certifier	Physician: To the best amlner: On the basis o and manner sta	examina	wledge, deat tion and/or in	nvestigation, in my	time, date and pl opinion, death o	lace, and due to the	e, date ar	s) and manner and place, and due	to the cause(s)
\O		Paymon 2 30. Name and address of person who				Print)		8			, 2009 up 2174
State Registra		31. Date field (Month, Day, Year)	32. Registra	2 8 2 ar's Signa		onk Hi	N Ave	o. Hay	est	my 1	ND AN

		For State Registrar	State of Ma	aryland.	•	rtment of F				009	206	9
Physicia /Medica Examine	al	1. Decedent's Name (First, Middle,  1. Decedent's Name (First, Middle,  4a. Facility Name (If not institution,  Carroll Hospice)	Alexana give street and number)		SR.	4b. City, Town, o	r Location of Deat	2. Date of Dea Month June 9	2009 4c. Count	Year	3. Time of De 4:11	
g 0 =	Be Completed by Funeral Director	214-28-1158  Usual Residence of Decedent  10a. State  Maryland  10b. County  Maryland  Carro  10e. Street and Number  3300 Harney Road  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  (Specity only highest  Elementary/Secondary (0-12)  11  17. Father's Name (First, Middle, L	12. Was Decedent E Armed Forces? 1   Yes 2   If Yes, Give Year or Dates:  s Education grade completed)  College (1-4or 5-	lo 1	Yrs.	Months Days	Specify: pation during most of word ator  18. Mother's Nar	Jul 27,	1930  10g. Citizen of  14. Ra Bli Spec.  16b. Kind of I  Lad  Maiden Surna	Mary  What Count  USA  Acce - Americ  ack, White, of  Business/Inc.	an Indian, etc. ite	Limits
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, inc. Medical Exponse.	<b>P</b>	Franklin Alex  19a. Informant's Name/Relationshi  Dorothy L. Alexa  20a. Method of Disposition  1 Buriat 2 Cremation  4 Donation 5 Other (Sp.  21. Signature of Funeral Service L	p (Type. Print) ander, wife  B □ Removal from State ecity)	20b. Plac	3300 re of Disposetery, crem	g Address (Street Harney F sition (Name of natory or other place Union ( Name and Addre 36 E Balt	and Number or Re Road, Tar  ce) Cem 6/13 ass of Facility	neytown,  Date  8/2009  Myers-Dun	er, City or Town MD 217  20c. Location  Keysv  Cboraw	87 ille, Funer	wn, State  MD a.l. Home	
Physician /Medical Examiner the prival-transit the prival-transit physician and the prival-transit physician and the prival-transit physician and the prival-transit physician p	dical Examiner	23a. Part : Enter the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a d. Due to (or a) d. Due to (or a)	a consequen	Do not enter control of the control						Approximate Interval Betwee Onset and De	en ath
es t igne	ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	23c. If yes, outcome of the birth of the bir	2 ☐ Fetal de time of deat	eath 3 th 5 th	Ectopic pregnanc Other (specify) nderlying cause giv			obacco use co		Pay Yes	ath?
9 9 0	Ó											

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law re within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sho

Medical Certification: To Be Complet

29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760,


25. Was case referred to medical examiner?	T			
1 Yes 2 □ No	Hospital:	1 Inpatient	2 ER/Outpatient	3□ DOA

1 ☐ Yes 2 ☐ K	10	Ho	spital: 1   Inpatient
. Manner of Death 1 Natural	5 ☐ Pending investigation		28a. Date of Injury (Month, Day, Y
2 ☐ Accident 3 ☐ Suicide	6 □Could not be		00 00 (11)

. Manner of Death		28
1 Natural	5 Pending	
2 Accident	investigation	
3 Suicide	6 ☐ Could not be	286
4 Homicide	determined	

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. Manner of Death		28a. Date of Injury
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4 D Hamisida	determined	28e. Place of Injury

i □ Pending	28a. Date of Injury			
investigation	(Month, Day, Year)			
6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome,		

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	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28c
			M	
	28e. Place of Injury - At ho	ome, farm, stree	t. facto	orv. o

6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, f	actory, office
1 Certifying Physi	cian: To the best of my kno	wledge, death occ	curred at the
2 ☐ Medical Examine	er: On the basis of examina and manner stated.	ation and/or investi	gation, in m

f	28c. Injury at Work?	28d. Describe how injury occurred
М	1 ☐ Yes 2 ☐ No	
eet, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

red at the time, date and place, and due to the time time, in my opinion, death occurred at the time	
29c. License number	29d. Date signed (Month, Day, Year)

24a. Was an autopsy performed 1 □Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

- ROBERT RICE,

26. Place of Death (Check only one)

29b. Signature and title of certifier	Rus	Mn	m
30. Name and address of person who	completed	cause of death	(Item :

D00	6459	7

29d. Da	te sig	ned	(Mon	th, Da	ay, Year)
	/			10	
6		1	<b>カ</b> /	7.	)
	(	16	/ (		

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【 No

M. D

30.	Name a	and ad	dress	of pers	on who	completed	cause	of death	(Item	23a)	(Type,	Prin
-	1-	Con.	12	3		102		- 1		01		

$\supset$	22	2.	Cer	iter	2
31.	Date file	d (Moi	nth, Day,	Year)	

h, Day, Year)	32. Redistrar's S
JUN 11 2009	Seneva

State

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PI	ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🕦

	1 - For State Registrar	State of Ma		epartment C <i>ertificate</i>				giene 2 (	09	20697
Dhysisian	1. Decedent's Name (First, Middle						2. Date of Dea	ath Day	Year	3. Time of Death
Physician /Medical	Madge Virginia	Ayres					June		2009	1105 M
Examiner	4a. Facility Name (If not institution		, ,	4b. City, T	own, or Locat	tion of Death			y of Death	
Funeral		10NQ Med 1CQ 6. Sex 7. Age	e (In yrs. last birtho	dav) If Under 1	Year If Ur	nder 24 Hrs.	8. Date of Birt	h	9. Birthpl	lace (State or Foreign
Director	218-03-4169	1 TM 0 TV	94 Yr	Months	Days Hou	urs Min.	8/7/19	14 Year)	Coun	MD MD
pu. ×	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					11/	Od. Inside City Limits
f sho		mico	Willar							1 □Yes 2 <b>X</b> □No
vith the Mar	10e. Street and Number	IIITCU	WIIIar	10f. Zip (	Code			10g. Citizen of	What Count	try?
h with	420 New Hope R	d.			21874			USA		
tter death v	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decede		c Origin? (Spexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America	
urs after death with the Marylan ral", or items 23a or 28a-f show Exb. of rear must be modified at 1 by Funeral Director	1 Never Married 2 Married 3 X Widowed 4 Divorced	ed 1 □Yes 2 X N If Yes, Give	10	1 □Yes 2		ecify:	, ,	Speci	4	ite
thour atural	15. Decedent	Year or Dates:	16a. D	ecedent's Usual	Occupation			16b. Kind of E		
ed within 72 houygiene. ner than "natura t, the Medical E	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or 5	(C	Give kind of work ife. DO NOT use	done during retired)	most of worki	ng			
ygien ygien t, ne	9 1		" Ho	memaker					1 Home	
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Expanie er must be motified at To Be Completed by Funeral Director	17. Father's Name (First, Middle, L						(First, Middle,		me)	
hould id Mer marke marke	Venton R. Adki		105.3	Mailing Address (			. Taylo		- Ctata Zia	Codo
and 2 s ealth ar m 27 is ner trau	Mary Lee Lambe		- 1	97 Regi				-		Code)
item	20a. Method of Disposition			isposition (Name crematory or oth			Date	20c. Location		wn, State
Pages nent of l ant: If its ary or o	1 XX Surial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			e Cemet		6/16	/2009	Willar	rds, M	D
permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Executions.  To Be Completed by F	21. Signature of Funeral Service L	icensee		22. Name and			urbage			
	23a. Part 1 Enter the disease, or o	complications that caused	the death. Do not				Berlin,		211	Approximate
Physician	shock, or heart failure. List of Immediate Cause (Final	only one cause on each lin	ie.	MON,			, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
/Medical	disease or condition resulting in death)	a Due to (or as a	a consequence of):		7					10443
Examiner	Sequentially list conditions	b								
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):	•						
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ficate be executed physician and sthe burial-transit		4	<b>-</b>							
tificate be ig physicia as the bur		7								
The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 ☐ Fetal death	3 ☐ Ectopic pre	egnancy			1	ate of delive	*
the at red for red for sicial	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		5 ☐ Other (spe				N	lonth	Day Year
hat the set by detack	Part II. Other significant condition	ns contributing to death bu	ut not resulting in th	ne underlying car	ise diven in P	Part I	23e Did to	obacco use cor	ntribute to th	e cause of death?
w requires that the do been signed by the should be detached leted by Physic		containing to countries	at not roomaning in a	io and onlying out	aco given iii			′es 2 No		
: The law requii cate has been s page 2 should							24a. Was	an 24h	Were autor	osy findings available
The large te has age 2							autop perfo	rmed2	prior to con death?	npletion of cause of
rtiffica ttor, p	25. Was case referred to medical					Place of Death	1 LaYes (Check only o	2 🗹 No   ne)	1 □ Yes	2 □ No
hysicit this cer al direct	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER/Outpa	atient 3 DOA	Other:		me 5 ☐ Resid		ther (Specify	)
Ing P	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injur (Month, Day		ıry	c. Injury at Work?		28d. Describe h	now injury occu	rred	
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tal or Attending Prs after death. Tal Director: After ted in by the funera Certification:	4 ☐ Homicide determin	ned 28e. Place of Inju	ry - At home, farm c. (Specify)	, street, factory,	οπισε		City or Tov		iber or Hura	l Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 ampletely filled in by the funeral director, page 2 Medical Certification: To Be Compl		Physician: To the best of								
the Hospi ithin 24 hou o the Funer ompletely fill	one)	xaminer: On the basis of and manner sta								
with Con	29b. Signature and title of certifier	_		29c.	License numl	ber 35		29d. Date sign	ed (Month, l	Jay, Year)
	100				1 18	رر		61.	NWG	
8A10	30. Name and address of person w				Mi. L		md o	1201		
State	31. Date filed (Month, Day, Year)	32. Registra	E. Corrol	1	11.2 DC	ry;	1144	7001		
Registrar	.IIIN 1 5	2009	1. 1	Marked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 1 9 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:00 Ам 2009 14, Melva Virginia Aaron June 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Greater Laurel Health and Rehab Ctr Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Virginia 91 June 6, 1918 213-42-5914 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 □ No Prince George's Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 USA 14200 Laurel Park Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🛛 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Berry Alvin Leigh Wynkoop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3101 Tremont Avenue, Cheverly, MD 20785 Ronald Aaron / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/17/2009 Rockville, Maryland Parklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility . Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rugers Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of delivery Year

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

Director

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in "Medical Event near the notified at once.

Baltimore, Maryland 21215-0036

anding physician and use as the burial-tran this certificate tal or Attending Physician: T's after death.

I Director: After this certificat ed in by the funeral director, pa To the Hospital
within 24 hours a
To the Funeral I
completely filled

Certification: To

27. Manger of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 6 2009

5 Pending investigation

☐ Could not be

determined

೨५ ೧೭ ರ್ ನಿರ್ಣ Division of Vital Records, P.O. Box 68760,

	shock, or heart failure. List or	nly one cause on each line.			Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of); b. Arria Fibrillation  Due to (or as a consequence of); c. Due to (or as a consequence of);  Due to (or as a consequence of);			
by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d		23d. Date of deli Month	very Day Year
	Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
Completed			24a. Was an autopsy performed 1 Yes 2	prior to o death?	topsy findings available completion of cause of 2 No
Be (	25. Was case referred to medical	26. Place of Dea	ath (Check only one)		
0	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 Residence	6 ☐ Other (Spec	cify)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darryll AntHony Hill, 13635 Baltimore Avenue, Laurel, MD 20907

28a. Date of Injury (Month, Day, Year)

and manner stated.

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 200 Eston Lee Alston, Jr. Ols /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Salisbur Wicomica Dice at the sasta 8. Date of Birth (Month, Day, Year) 10-31-1944 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F 64 NC Director 240-72-5604 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Important; if item 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Examiner must be reclined at 1 XYes 2 No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 525 Alabama Ave, Apt 28 21801 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify <u></u> Black 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Engineer 9th Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Louise "Unknown" ၉ Eston Lee Alston, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lakeisha S. Alston/Daughter 420 Cartwright Ave, Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Crematory, 6-20-2009 Dover, DE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Salisbury, MD 21801 se, or complications that caused the death. Do not another the mole of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part1. Ent the disease shock, or heart to ure. Onset and Death Immediate Cause (Final ESOPHAGRAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) many, leading to ministractive cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2/□No 1 ☐ Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Division of After thi funeral of 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 109 0058410 30. Name and bress of person who completed cause of death (Item 23a) (Type, Print) BOX AUSBUMP aup 733

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Rea. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 2:18 P Marylyn Evelyn Breakall June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 14244 White Oak Ridge Hancock Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 17, 1938 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1 □ M 2√□ F 70 Yrs. WV 220-34-2222 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or Items 23s or 28e-f show the Medical Evantiner must be notified at 1 ☐ Yes 2√2 No Washington Hancock MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21750 14244 White Oak Ridge 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes ZYXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Saltimore, Maryland 21215-0036 <u>م</u> White 3 ☐ Widowed 4 ☒ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Menial Hygiene. Important: If item 27 is marked other than "ns any injury or other treumetic event, the Media once. Store Elementary/Secondary (0-12) College (1-4or 5+) Retail Convenience Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret M. Bell Melvin E. Gladhill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14244 White Oak Ridge Hancock, MD 21750 Ray A. Breakall/Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 06/20/2009 Smithsburg, MD 141 West Main Street 22. Name and Address of Facility 21. Signature of Funeral Service Lig Mol4/4 Grove Funeral Home, P.A. Hancock, MD 21750-0368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) rancrest 10 Pnysician ancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performe 1 Yes 2 M No : After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Nesidence 6 □Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ို 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 27. Manny of Death Certification; 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 56048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Pennsylvinia North Hvenus 32. Registrar's State Registrar

		1	State of Maryland / State of Maryland / State Amend Item 21 per fh, g892,0	Depa 6/29 Cer	rtment of F <b>/09dhb</b> tificate of i	lealth and Death	Mental Hygi	ene g. No.20	09	20701
Phys	sician		1. Decedent's Name (First, Middle, Last)  Merdella Bailey				2. Date of Death Month	Day	Year	3. Time of Death
	edical				4b City Taylor	Leasting of Dog	March 1	1, 200 4c. County		12:00 p. <sup>M</sup>
Exar	miner	4	ta. Facility Name (If not institution, give street and number)  Summit Park		4b. City, Town, o	nsville	ın		timor	e
Funer	ral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthpla	ace (State or Foreign
Direct			152–48–2882 1□ M 2X□ F 89	Yrs.	Months Days	Hours Min	10/16/19	19	Jam	aica
pu »		-	Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Lo	cation				10	d. Inside City Limits
f sho	5		,	Fulto						1 □Yes 2 <b>X</b> No
the N	Director		10e. Street and Number		10f. Zip Code		11	Og. Citizen of	What Count	ry?
h with 23a or		5	11988 Scaggsville Road			20759		USA		
Baltimore, Maryland 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Engineering to confine any	hy Europe	5	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □Yes 2 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)		ce - America ck, White, e	
5-0 72 ho natur	Completed		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of wo		16b. Kind of B	usiness/Ind	ustry
ithin in hear "hear"		5	Flomentary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired ing Assis	d)		Priv	ate	
12. Hygie ther th	8		17. Father's Name (First, Middle, Last)	uar D I	ing more		me (First, Middle, N			
land lid be f Mental I rked of	a of	5	Andrew Anderson				ha Watson			
Baltimore, Maryland 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or any hilury or other traumatic event, Its Medica Era is any lailury or other traumatic event, Its Medica Era is any lailury or other traumatic event, Its Medica Era is any lailury or other traumatic event.							Rural Route Number			Code)
of Hear		1	20a. Method of Disposition 20b. Place cerne	e of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	wn, State
Page Page nent (			1 A I Burial 2 I I Cremation 3 L I Bernoval from State 1	t1awr	n Mem. Ga	r.  03/2		larriot		
Balti permit, Departr Importa	ouce.		21. Signature of Funeral Service Licensee Christopher P. Alston per D				Bean, Als indover, N			13
hysician and in the principle of the property of the property of the principle of the princ	eal ier	Evallill	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Persistent  Due to (or as a consequent Multiple St.)  Due to lor as a consequent Hypertension  C.  Due to (or as a consequent of the	ce of): rokes ce of): n		ate				Önset and Death
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifics releath. extor: After this certificate has been signed by the attending ply the funeral director, page 2 should be detached for use as I by the funeral director, page 2 should be detached for use as I		Iysiciali/iwed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	ath 3	☐ Ectopic pregnand ☐ Other (specify) _	су			ate of delive	ery Day Year
rds, P. quires that n signed b lid be deta		<u>~</u>	Part II. Other significant conditions contributing to death but not resultin Renal Insufficiency, Congesti					obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Hundenway		
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Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, deat n and/or ir	th occurred at the forcestigation, in my	ime, date and pla opinion, death oc	ice, and due to the courred at the time, of	cause(s) and r date and place	manner as s e, and due to	stated. the cause(s)
To the within Fo the		E -	20h Cianglura and title of contifier	,	29c. Licen	se number		29d. Date sign		
F>F0			ATTENONIA		D56	948		MAR	13	2009
7		-	30. Name and address of person who completed cause of death (Item 23	3a) (Type,	Print)					
			James N. Tansinda, MD, 300 Armor			3H, Ba	Ltimore,	MD 2120	)1	
	State gistra	r	31. Date filed (Month Day Year) 2009 Registrar's Signature 2009	40	ale					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6/12/2009 12:30 AM June Mildred Becker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Ridge Overlook Assisted Living Westminster If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1/1/1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🛭 F Months Days Hours NY 82 Director 115-18-7609 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Madical Even, the first by notified at 1 ☐ Yes 2 No Director Carrol1 Westminster MD the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with IISA 21157 3816 Ridge Rd. Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the shours after on the should have the 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXVo Specify Specify: White þ 3X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company 12 Executive Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be Florence Floyd Clarence Cummings ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Gail Becker/Daughter 303 Carroll Ave., Mt. Airy, MD 21771 other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 6/12/09 Winfield, MD 4 ☐ Denation 5 ☐ Other (Specify) Carroll Crematory 21. Si mature of Funeral Service License <sup>22</sup>Burrier-Oueen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death 2 a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one gause on each line. mmedi te Cause (Final **Physician** mos. End Stage Alzheimer se or condition resulting in death) /Medical Due to (or as a consequence of) Examiner mos. Cerebral Vascular Accident Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hypertension Due to (or as a consequence of): P.O. Box 68760. Physician/Medical vr. Osteoporosis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 1 ☐ Yes XIX No 3 ☐ Probably 4 ☐ Unknown Failure to Thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 2**X**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) Assisted1 ☐ Yes 29 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Living Division 5 Pending investigation 1X Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tale WJL June 12, 2009 D 54749 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) D-1, Frederick, MD 21701 Allen Reilly, 801 2611house Ave., MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		Pleas	se Type or Prii State of M					Mental Hyg		
		For State Registrar	Olato of M	ar y larra /	•	tificate of			eg. No. 2	20703
Physicia		1. Decedent's Name (First, Middle MARGARET	e, Last) ELLEN	BOI	LING	FR		2. Date of Deat Month JUNE 10	h Day Year	3. Time of Death 7:54P
/Medic Examine		4a. Facility Name (If not institution	, give street and number,				Location of Deat		4c. County of Dea	
/		FREDERICK MEMO				FREDER		T =	FREDERI	
Funeral Director		216-05-2026	6. Sex 7. Ag	ge (In yrs. last 92	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1916 Mar	thplace (State or Foreign ountry) yland
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	cation	·			10d. Inside City Limits
72 hours after death with the Maryland natural", or items 23a or 28a-f show diest Exercitive met by motths of an	ӯ	-	erick			10f. Zip Code	Woodsbor		0g. Citizen of What Co	1 Yes 2 No
th with t 23a or 3	al Dir	10e. Street and Number 11119 Hill Road				Tot. Zip Code	21798		USA	
tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whit	
ours afte	by F	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Give			□Yes 2XNo	Specify:		Specify: W	hite
"natura		15. Decedent	's Education		6a. Deced	dent's Usual Occup	ation	rking	16b. Kind of Business	/Industry
filed within 72 ho Hygiene. other than "natus ent, the Medical	Completed	(Specify only highes Elementary/Secondary (0-12) 12	College (1-4or	5+)		kind of work done DO NOT use retired Homemaker		rking	Own Hom	е
tal H d oth	To Be Co	17. Father's Name (First, Middle, I						me (First, Middle, F et E. Ja	,	
nd 2 shou alth and M 27 is mar r traumat	_	19a. Informant's Name/Relationsh Harold S. Bollin						ural Route Number Isboro, M	r, City or Town, State, D 21798	Zip Code)
ages 1 a ent of Hecentric If item		20a. Method of Disposition  1 Maurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp				sition (Name of natory or other place rg Memori			20c. Location - City of Emmitsburg	
permit. P Departm Importar any inju		21. Signature of Funeral Service I				Name and Addre			boraw Fune , MD 21727	ral Home
bur icia	sal Examiner	83a. Part1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	line.	ce of):	er the mode of dyli	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
the d	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal de	ath 3 [	Ectopic pregnand Other (specify)	cy		23d. Date of di Month	olivery Day Year
w requires that s been signed be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23  Differ Mellin Mellin Sulve						23e. Did to	bacco use contribute es 2⊠No 3□ F	o the cause of death?  Probably 4 Unknown
ician: The law requestificate has been ector, page 2 should	Completed							24a. Was a autops perfor 1 □Yes	sy prior to med? death?	utopsy findings available completion of cause of s 2 □No
certifi rector	Be	25. Was case referred to medical examiner?	Haspital			See Oth	Or:	ath (Check only or		
ng Phys fter this neral dii	on: To	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1 □ Inpat	tient 2 ☐ ER jury 28 <i>pay, Year)</i>	Outpatier  b. Time of Injury	IL 3 DOA	4 LI Nursing		ence 6 Other (Sp ow injury occurred	ecify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	gation and be 28e. Place of Ir	njury - At home etc. (Specify)	, farm, str	M 1 =	]Yes 2□No	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
Hospital 4 hours a Funeral I		(Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	of examination						
To the I within 2 To the I complet	Medical	29b. Signature and title of certifier	and manner s	stated.	-	29c. Licens	se number 3 4-30 3		29d. Date signed (Mor	oth, Day, Year)
MIL		30. Name and address of person	who completed cause of	death (Item 23	Ba) (Type,	Print)		*	JUNE 11 2	21701
Sta	te	IRFAN W. HA: 31. Date filed (Month, Day, Year)	32. Regi	rar's Signature	9		venue (	FREDER	rick, Ma	1.21701
Registra		JUN 1		news	B. ,	parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22387 M **Physician** -2009 12 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci If Under 2 lnion If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min. 045-30-790 1-25-19 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Director eci 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1□Yes 2XNo 3altimore, Maryland 21215-0036 Specify. Specify: Whit þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany Injury or other traumatic." College (1-4or 5+) Elementary/Secondary (0-12) e 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Mural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pouse Millestone 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 6/18/09 4 ☐ Donation 5 ☐ Other (Specify) Veterans Mey. Cemetery 22. Name and Address of Facility

5+vano + Feeley 21. Signature of Funeral Service Licensee Home Mound 19702 635 hurchmans e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Physician DICA /Medical Due to (or as a consequence of): Examiner RDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner neuMON; A ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a, Date of Injury 28b. Time of 27. Manner of De 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 28b. Signature and title of certifier

√D State

Registrar

I I MO HAY O 31. Date filed (Month, Day, Year)

02

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

32. Pegistrar's Signature

Signature Sanks

		State of Maryla		artment of F			201	19 20705
		Registrar  1. Decedent's Name (First, Middle, Last)		lilicate of	Dealli	2. Date of De	neg. Not 🔾 🔾	3. Time of Death
Physic		Dorothy Irene Bailey				06/12/2	Day	4:01P M
/Med Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Dea		4c. County of	
1		Suburban Hospital		Bethesd	a, MD		Montgo	mery
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yill 1 M 2X) F 76	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, Year) 1933	9. Birthplace (State or Foreign Country) Chile
		Usual Residence of Decedent				05/04/	1755	
arytar show	7	10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M	Director	MD Montgomery Ke	nsingto	10f. Zip Code	· · · · · · · · · · · · · · · · · · ·		10g. Citizen of Wh	
with	Ö	11235 Waycross Way		208	95		United S	
death ms 2:	Funeral	11 Mayital Status 12 Was Decedent Ever in	U.S. 13.	Was Decedent of H		Specify Yes or No		- American Indian,
after or ite	J.	Armed Forces?  1 Never Married 2 Married 1 Yes 2 MN  If Yes, Sive		irYes, specify Cuba 1. XIYes 2. □ No				White, etc. White
ural",	d by	3 ☐ Widowed 4 💹 Divorced Year or Dates:						
in 72	Completed	15. Decedent's Education (Specify only highest grade completed)	Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind of Bus	ness/industry
d with giene ar than	lmo	Elementary/Secondary (0-12) College (1-4or 5+)		rpreter	<i>'</i>		Educati	.on
tal Hy dothe	Be (	17. Father's Name (First, Middle, Last)					, Maiden Surname,	)
y la hould t d Men narke natic e	ဥ	Abbott Kittredge Bailey				Gutierr		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any hipry or other traumatic event, In Medical Evanime 1, 181 by neithed at mone.		19a. Informant's Name/Relationship (Type. Print)  Dorothy Alexander/Daughter	1	ng Address <i>(Street</i> 5 Waycros			er, City or Town, S	itate, Zip Code) 18 <b>95</b>
es 1 a of Her litem		20a. Method of Disposition 20b	. Place of Dispo cemetery, cren	sition (Name of natory or other place	e) 06/1	Date / / 2000		City or Town, State
: Pag tment tant: h	4	4 □ Donation 5 □ Other (Specify) Me	tropoli	tan Crem	atoŗĭum'		Alexandri	
Departing any in	NIIX	21. Signature of Funeral Service Licensee					vler's So ashington	
		23a. Part 1. Enter the dise se, or complica one that caused the de shock, or heart failur. List only one cuse on each line.						Approximate Interval Between
Physician	1	Immediate Cause (Final disease or condition Chronic						Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a conse	equence of):					
		Sequentially list conditions,  Due to lor as a const	egrience of):					
cuted ad ansit	Examiner	Sequentially list conditions, if any head to the interest of the course. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events c.						
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a conse	equence of):					
icate b physic the b	dical	d						
death certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg	nancy				23d Date	of delivery
death	Physician/Me	in the past 12 months? 1 ☐ Live birth 2 ☐ Fe		] Ectopic pregnanc ] Other <i>(sp</i> ec <i>ify)</i> _	у		Mont	
that the ded by the	Phys	9 Unknown						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not re			oute to the cause of death?  B Probably Unknown			
law recast bee	Completed					24a. Was	an 24b. W	ere autopsy findings available ior to completion of cause of
	Je mo					auto perfo 1 □ Yes	rmed? de	lor to completion of cause of eath? □Yes 2□No
	Be (	25. Was case referred to medical examiner?				eath (Check only o		
this aldiu	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	ER/Outpatier		4 🗀 Nursing		dence 6 □Other	
ding l h. After funer	ertification:	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	y at ⟨? Yes 2 □ No	28d. Describe	how injury occurred	1
Attending r death. ector: After by the funer	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, str		103 2 2 110			r or Rural Route Number,
rs affer al Dir	O	4 ☐ Homicide determined building, etc. '(Spe	City)			City or To	wn, state)	
To the Hospital or Attending Physician, within 24 hours after death.  To the Funeral Director: After this certifit completely filled in by the funeral director.	ledical	29a. Certifier (Check only one)  Medical Examiner: On the bast of examinarine)  and manner stated.						
To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed	(Month Day, Year)
5		M) (1) me M)		0	31021		06/1	3/09
		30. Name and address of person who completed cause of death (It	em 23a) (Type,	GENELT	and RE	BET	ACIDA	mb 20814
St Regist	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature A.	Print) GEVILLEY				
			/- /7	7)				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Laurence Behall June 11, 2009 7:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year)
July 28, 19 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** 1 M 2 □ F 272-36-1818 68 Ohio 1940 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location s 23a or 28a-f show 1 ☐ Yes 2 TXNo Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 206 East Indian Spring Drive 20901 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ir than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☑ Yes 2 □ No If Yes, Give 1962–66 Year or Dates: 1 Never Married 2x Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Information Technology Federal Government event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Alfons Behall Anne Zinz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Behall/Wife 206 East Indian Spring Drive, Silver Spring, MD 20901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State June Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Francis J. Collins Funeral Home Inc <del>50</del>0 University Blvd. W., Silver Spr Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of burial-trar exec Due to (or as a consequence of) Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a o 9 Hlnknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 □Yes 2 No 1 Tyes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🖾 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 11, 2009 D43539 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravmond White, MD 1500 Forest Glen Road, Silver Spring, MD 20910 32. Registrar's Signature State Registrar

09-04650 Claire Bursley

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

a <b>= a</b>		1- For State  Certificate of Death Registrar	Reg	201	19 2070
Physici	an/	Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death
ledical Exami	ner	Claire Mulvany Bursley  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dec	June 11, 20	09 4c. County of Death	0627 hrs
		Laurel Regional Hospital		Prince George	
Funeral Director		553-30-1873 1 M 2 XX 81 Yrs. Months Days Hours N	/lin.		thplace (State or Foreign untry) California
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<u> </u>	ь	Maryland Prince George's Silver Spring			1 Yes 2 X No
b, MD 21215-0036 and 2 should he filed within 72 hours after death with the Maryland teath and Mental Hygiene. tenth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f sho trammatic event, the Medic 4 Examiner must be notified at once.	Director	10e. Street and Number       10f. Zip Code         3144 Gracefield Road, #406       20904		. Citizen of What Cou JSA	ntry?
death with rritems 2:	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	White, etc.	ican Indian, Black,
s after ral", o	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify:	7	Specify: Whit	
2 hour "natu	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Lorrowalk or		16b. Kind of Business/	
1036 vithin 7. ene. rr than	ompleted	4 Homemaker		Own Ho	ome
215-0036 he filed within 7 ntal Hygiene. rked other than	ပ		mme (First, Middle, Ma ude Hyland	·	
212 212 ould he I Menta marko ic even	Го Ве	19a. Informant's Name/Relationship (Type. Print.)  19b. Mailing Address (Street and Number of Street and Number of	or Rural Route Numb	er. City or Town. State	e, Zip Code)
MD nd 2 sho alth and m 27 is		G. H. Patrick Bursley/Husband 3144 Gracefield Road			
Baltimore, MD 21215-0036 permit. Pages I and 2 should he filed within 72 hours al Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	١	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory	June 13,	20c. Location - City or	Town, State
Itim nit Pag artment ortant:	a	4 Donation 5 Other Specify:	2009		a, Virginia
Department of the permanent of the perma	, 1	21. Signature of Funeral Service Licensee 22 Name and Address of Facility 1 500 University 1	ins Funera Blvd. W.,	Silver Sp	ring,MD 2090
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
caminer		Immediate Cause (Final disease or condition resulting in death)  Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
	L	Sequentially list conditions, b.			
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Uncerlying Cause (Disease or injury that initiated			
rted d ansit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
760, ficate be g physici		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	
Box 687 he death certific the attending p	iciar	past 12 months?  [4] Pregnant at time of death 5 Other (Specify)	gnancy	Month	Day Year
O. Bo t the dear by the ar	Physician/	Yes 2 ✓ No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did toh	pacco use contribute to	the rause of death?
ires that to signed by leedetac	þ	Chronic Obstructive Pulmonary Disease			bably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir staler death. al Director: After this certificate has been siled in by the funeral director, page 2 should I	Completed		24a. Was a		utopsy findings available completion of cause of
Vital Reco hysician: The law this certificate has I director, page 2 s	отр		perform 1 <b>V</b> Yes 2	ned? death?	_
tal F cian: certifi ector,	ВеС	25. Was case referred to medical examiner? 4. Hospital: 1. Inpatient 2. FR/Outpatient 3. DOA Other Number 1. DoA Other Number			
n of Vi ling Physi After this funeral dir	၉	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Other	er:
OD C euding sath. or: Af the fun	tion	1 Ves 2 No			
Division spital or Attentions after death reral Director: filled in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City
ospital hours uneral y filled	O	4 Homicide determined (Specify)  29a. Certifier 4 Continue Physical Table has been founded as the survey of the line data and less than the li			atod .
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	Me	296. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
5	(	(actuleally) O.C.M.E.		June 12, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
	tate	31. Date filed (Month 1917) ear 5 2000 32. Resistrar's Signature			
Reais	trar	JOH I D 2009 Leneur B. Back			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 54am 009 BROWN-JACKSON LEE DONNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mata naries If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, JAN 18 1936 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday) **Funeral** Days Hours Min. WASHINGTON, DC 1 □ M 2 🖾 F 578-76-1860 Yrs. 53 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or items 23a or 28a-f show traumatic event, the Medical Examinar must be putified at 1 TyYes 2 □ No Director LUSBY MD CALVERT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20657 342 RED CLOUD ROAD Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married BLACK (CKSO), DOOO Waltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ≥ 3 Widowed 4 Divorced and Mental Hygiene. is marked other than "natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SALES 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( DOROTHY L. RICHARDSON JAMES D. FEATHERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 342 RED CLOUD ROAD LUSBY, MARYLAND 20657 HAMPTON JACKSON JR./HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND RIVERDALE CREMATORY 6/12/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21 Signature of Foneral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CETTERS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 T Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. Day, Year) 29d. Date signed (Month. 29c. License number 29b. Signatute and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pembrooke Sy Suite 103 Waldorf MD

State Registrar George

JUN 1 6 2009

eyonna	a Shawr		1. For State	/ Depa	artment of I	Health ar				2 f	nna	2070
	D1		Registrar 6_18_09Amend#20b20c, PerFHRT  1. Decedent's Name (First, Middle, Last)	cr Cer	rtificate of L	Jeatn ———		Tá	Reg Date of Death	j. No.		3. Time of Death
	Physicia I Exami		KEYONNA SHAWN'TA BOWSER							Day Y∈ )9	ear	2337 hrs
			4a. Facility Name (if not institution, give street and number) Eastbound Suitland Parkway E. of Suitlan			City, Town, o Suitland	r Location o	of Death		4c. County Prince	George'	s
	uneral irector		578-17-8461 1 M 2X F	e (In yrs. Ia	ast birthday) Yrs.	If Under 1 Ye Months Day		_	8. Date of Birth	,		pplace (State or Washington DC
	w any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	1			<u> </u>			10d. Inside City Limits 1 X Yes 2 No
	with the Maryland ns 23a or 28a-f show be notified at once.	Director	Maryland Prince George's  10e. Street and Number	Cap	oital He	ights 10f. Zip Code			10	g. Citizen of V	Vhat Count	
-	3a or		1410 Lorton Ave.			20743			Un	ited S	tates	
Aprox 1	be filed within 7.2 hours after death with the Maryland mall Hygiene. Red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces?			Decedent of H , specify Cuba					e - Americ te, etc.	an Indian, Black,
4	ral",	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:			es 2 X N					Blac	
	led within /2 hours Hygiene. other than "natur	ted	15. Decedent's Education (Specify only highest grade con  Elementary/Secondary (0-12)  College (1-4 or		16a. Decedent's during mos	Usual Occupa t of working lif				16b. Kind of B	usiness/In	dustry
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0-0	ed wit tygien other he Me	Completed	17. Father's Name (First, Middle, Last)		_ onempto	Jyeu	18.Mother	s Name (F	irst, Middle, M			
21215-0036	Mental H marked c event,	å	Tim Bridgwaters		The EWiscode Sales				Mallard			, s
21	should and Mer 7 is man natic ev	P	19a. Informant's Name/Relationship (Type, Print )		19b. Mailing A							
≥ 5	I and 2 shou Health and I fitem 27 is a r traumatic	П	Tonette Bridgwaters / Moth		11410 Lo	orton A	Ave. C		al Heig	hts, M	aryla - City or 1	and 20743
Baltimore,	rages I and z shou ment of Health and N fant: If item 27 is n or other traumatic		1 K Burial 2 Cremation 3 Removal from St	ete Hai	crematory or other	morial	Park				•	aryland
E E	permit. Fages I Department of H Important: If i injury or other		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Res	<del>surrecti</del>	<del>)11</del>			/2009   Funera			
Ba	E De E		KRIST G. Suray MOLDS	5				-				11and 20747
	ysician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.								Approximate Interval Between Onset and
	ledical aminer	4	Immediate Cause (Final disease a. Head and Neck								- 9	Death
			b	equence of	f):							
		ner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause	equence of	f):							
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	oe executed ician and irial - trans	dical	d. UNPENDED AMENDED									
n of Vital Records, P.O. Box 68760,	reatn ceruticate be executed e attending physician and for use as the burial - transit	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1		2 Fetal	death 3	Ectopic	pregnanc	/	23d. Date of Month	of delivery D	ay Year
P.O. E	res that the de signed by the be detached f	by Phy	Part II. Other significant conditions contributing to death	but not re	esulting in the und	lerlying cause	given in Pa	rt I.		acco use con		he cause of death?
ords, l	w requires is been sig should be	Completed							24a. Was ar	n 24b.	Were aut	opsy findings available ompletion of cause of
Reco	ysician: The law his certificate has director, page 2 sl		25. Was case referred to medical			26 Plac	e of Death (	Check onl	perform	ned?	death? 1 🕢 Yes	2 No
Vita	this cer I direct	o Be	examiner? Hospital:	nt 2	ER/Outpatient		Other <sub>4</sub>	Nursing H		tesidence 6	<b>✓</b> Other:	Scene
on of	eath. or: After t		27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred									cident
Division of Vital Records,		Certification:	2 V Accident Investigation 3 Suicide 6 Could not be determined (Specify) Inte		ome, farm, street,	factory, office	building, etc		or Town, Sta	ate)		al Route Number, City Suitlan, Suitland, MD
Divis	in 24 hours in 24 hours he Funeral pletely filled		29a. Certifying Physician: To the best of money one 2 Medical Examiner: On the basis of examiner: On the basis of examiner:	y knowledg	ge, death occurre			ice, and du	e to the cause	(s) and mann	er as state	d.
Ę	within To the comple	Medical	and manner stated.  29b. Signature and title of certifier				se number	ourrou at ti	io timo, dato d	29d. Date sig		
	10		(& Sorley W)				.M.E.			June 8, 20		.,,
	01	Ì	30. Name and address of person who completed eadse of c Laron Locke MD. Assistant Medical Ex	,	111 Penn S	Street Balt	imore MAI	D 21204				
0	6/	ate				ueet, baiti	inore, Mi					
	Si Regist	ate	31. Date filed (Month, Day Xaar) 32. Registra	Joignald	take							

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month Day, Year) JUN 16 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ( 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Edith H. Cole June 8. 2009 9:15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring

| FUnder 1 Year | FUnder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 22, | Advantage Assisted Living Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗓 F Virginia ′1920 Yrs 89 Director 578-18-2646 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State show ral", or items 23a or 28a-f shor Exerciper must be notified at 1 ☐ Yes 2 X No Funeral Director MD Burtonsville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15233 Lions Den Road USA 20866 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No White If Yes, Give Year or Dates: Specify. Specify: Completed by 3 Widowed 4 Divorced "natural", er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Bernard Hoddinott Ella Mae Black ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lindell B. Cole / Husband 15233 Lions Den Road, Burtonsville, MD 20866 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 06/15/2009 Brentwood, Maryland Fort Lincoln une di Seri e Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatur 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 weeks Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physician and use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) 68760 by Physician/Medical attending properties for use as IF FEMALE: O. Box 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year signed by the a 5 Other (specify) 1 ☐ Yes 2 🛛 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 s autopsy performed? certificate 1 □Yes 2X No Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 ☐ Yes 2 🏋 No 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA ot After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division Injury 1 X Natural 5 Pending 1 □Yes 2 □No investigation within 24 hours after death

To the Funeral Director; ,
completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-178 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave., Cottage City, MD 20722 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE **Physician** 2009 Dorothy Marie Cox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AT1. a CIVISTA MEDICAL CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct.15,1927 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 579-26-5830 II. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show the Middeal Exercitive roust be notified at Director 1X Yes 2 □ No MD Charles LaP1ata 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 113 Madison St. U.S.A. "natural", or items 23a 20746 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 🐼 No White Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Insurance Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Groves Dorothy Carter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) them 27 other tra of Health Sandra L. Hendricks/Daughter 3863 Pine Cone Cr., Waldorf, MD 20602 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If It any Injury or conce 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 6/17/2009 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home Musne 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Do not enter the mode of dying, such as cardiac or respiratory are st Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fo Physician; The law requires that the death certificate be executed physician and the burial-transit P.O. Box 68760, Physician/Medical as IF FEMALE use If yes, outcome of pregnancy (
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 5 Other (specify) 1 ☐Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be ģ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1 ☐ Yes After this certifiing funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 2 ☐ Accident (Month, Day, Year) Injury 5 ☐ Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö To the Hospital e Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif License number

State Registrar

DHMH 17 Rev 1/2001

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0807FL

3460 OLD WASHINGTON PD #203A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

COLLINS P. SEIN MD

31. Date filed (Month, Day, Year)

JUN 1 6 2009

DORF

20602

WAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 10 7:30a Ruby C. June Cowan 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2533 Glen Allen Avenue #2 Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 8/11/1935 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours Months Days 1 □ M 217 F Virginia 73 230-42-1334 Usual Residence of Decedent

10f, Zip Code

1 ☐ Yes 2 K No

20b. Place of Disposition (Name of cemetery, crematory or other place)

20906

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10c. City, Town or Location

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █ No

1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:

College (1-4or 5+)

Silver Spring

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

Private

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2533 Glen Allen Ave., #2, Silver Spring, MD

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Month

20906

14. Race - American Indian, Black, White, etc.

**Black** 

20722

Approximate Interval Between Onset and Death

6 weeks

years

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Year

USA

1 X Yes 2 No

Saltimore, Maryland 21215-0036 permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any injury or other traun once. Physician /Medical Examiner

**Physician** 

/Medical

Examiner

1∩a State

Maryland

10e. Street and Number

10h County

2533 Glen Allen #2

1 ☐ Never Married 2 ☐ Married

3 X Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Daniel

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Donnell Cowan - Son

Montgomery

15. Decedent's Education (Specify only highest grade completed)

Haley

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

**Funeral** 

Director

28a-f show

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23a

or items

"natural",

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r

72 hours after

Director

Funeral

Completed

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traumatic event, the Medical Examiner must be notified at

Examine attending physician and for use as the burial-tran Physician/Medical signed by the a d be detached fi ੬ icate has been si Completed certificate funeral director, Be this Certification: To Plospital or Attending Plant Plant Appending Plant Appending Plant Appending Plant P After t

the

filled in by

Medical

within 24 hours a

To the Funeral D

completely filled i

8

the

law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Ft. Lincoln Cemetery | 6/19/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home B401 Bladensburg, Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Liver Failure disease or condition resulting in death) Due to (or as a consequence of): Metastatic Adenocarcinoma Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ulcertive Colitis Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown <u>Coronary Artery Disease</u> 24a. Was an autopsy perforn 1 ☐Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🎛 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jack Epstein, MD

32. Registrar's Signature

10810 Connecticutt Ave., Silver Spring, MD

Registrar DHMH 17 Rev 1/2001

State

JUN 1 6 2009

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

back

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 22, 2009 9:35A ROBERT JUNE. THOMAS DUTROW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/21/1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M M 2 □ F Maryland 83 220-18-1438 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eval, inc., ust be rediffed at 1√ Yes 2 No Director Frederick MD Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21701 313 Willow Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 44–46 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other traumatic event, I'm Mydle once. College (1-4or 5+) Elementary/Secondary (0-12) state government sanitarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Putman R. Thomas Dutrow, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 625 Wilson Place, Frederick, MD 21702 Victoria Hill/ daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2009 Frederick, MD Mt. Olivet Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses acquelle Kne 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COLON CANCER 4 VEAR Immediate Cause (Final disease or condition resulting in death) TASTAT Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Vear Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ SEIZURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? - ATRIAL autopsy performe 1 ☐ Yes 2 X No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2+1 State

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 1/2001

Dr. Florin Rusu/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0612212009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend item 8 per in 8894 8-5-09 vt.
State of Maryland / Department of Health and Mental Hygiene [] [] 9 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 16:05 PM 20 wa1 06 610519 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegan mberla Memoria 0 ampi 9. Birthplace 8. Date of Binho (Month, Day, Year) 5. Social Security Number **Funeral** Min 1 □ M 2 🛛 F 1935 Maryland 74 Yrs. Director 214-34-1240 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 🔀 No traumatic event, the Medical Evantinar roust by notified Allegany Cumberland Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō U.S.A. 21502 23a 12806-B Cresap Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 1 □ Yes 2 🛣 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any Injury or other traumatic event, the Once. Restrauant Waitress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Neva Josephine (Wilson) Frank Bowles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12806-B N. Cresap St., Cumberland, MD 21502 Stephen DuVall 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 22,09 | Cumberland, MD Scarpelli Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A. re of Funeral Service Licenses 1302 National Hwy., LaVale, MD 21502 23a. Parth. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each time. Approximate Interval Betyeen Onset and Death Immediate Cause (Final disease or condition resulting in death) NEU Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been executed. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUMB., MD 21507 SETONDRIVE 31. Date filed (Month, Day, Year) State JUN29

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ercy 2009 1227 TU 25 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Doxdam Germantown 11601 Terr If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
S. Dakota 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F 85 Yrs Nov. 501-14-6885 6, Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2♥ No Directo Maryland | Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11601 Doxdam Terrace 20876 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White 5 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Meat Cutter Grocery Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Arthur F. Dahlke Cecilia Sorensen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis W. Dahlke - Son 11601 Doxdam Terrace, Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Qurial 2 □ Cremation 3 □ Removal from State Riverside Cemetery June 12, 2009 Aberdeen, S. Dakota 5 Other (Specify) 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Eneral Service 1 nsee 26401 Ridge Road, 20872 Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SC **Physician** Dme disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO DME 50428 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month

BRECKER, MO OME

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 9, 12:40 p M Harvine Virginia Ebaugh 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Taneytown Carroll Lorien Nursing & Rehabilitation Ctr If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🗙 F 97 219-12-0416 1911 Maryland Sep 21, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a State 10h County 28a-f show 1 Yes 2 No Hanover York Examiner must be notified Penna Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Items 23a or USA 17331 653 Fulton Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No white Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales Associate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jane Yingling Joseph M. Myers ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 653 Fulton Street, Hanover, PA 17331 Paul E. Ebaugh, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. John's (Leisters) 6/12/2009 Westminster, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** loans disease or condition resulting in death) wan /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? significant conditions <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be No Hospital: Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 □ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b/. Signature an WJL 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

**JUN 11** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 **Physician** 11:55 P<sup>M</sup> Anna Mae Forstrom /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/11/1922 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 □ M 2 🛛 F 87 Vrs 016-18-0868 MA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at 1 XYes 2 No Funeral Director MD Worcester Ocean City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21842 13332 Nantucket Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed by 2 should be filed within 72 hours and Mental Hygiene. white 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Government laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raffael Ferragamo Rose Belmont 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6621 Allen Lane, Columbia, MD 21045 Kathy Baker / daughter other ltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ţ Department of Important; If it any Injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 6/15/2009 Elkridge, MD 4 Donation 5 ther (Specify) 22. Name and Address of Facility 21. Signalure of Funeral Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1 Friter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cource Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for a consequence of) sician and burial-trans Due to (or as a consequence of): attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes Vital After this certification funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. t hours after death. 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 how To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

6/12/09

Flourck Island, De 19944 29b. Signature

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State Registrar Year)

Registrar's Signatur

npleted cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1	For State Registrar	State of Maryli			e of Dea			Reg. No	.2009	2012
8	Physicia		1. Decedent's Name (First, Middle, Las EDWARD CHARLE	FEAUE					2. Date of De Month  June 1	Da	y Year	3. Time of Death 19:20 p <sup>N</sup>
	/Medic	1.0	4a. Facility Name (If not institution, give			4b. City	Town, or Loca		June 1		. County of Death	
4	Examin	er	Montgomery Genera			01r				М	on t gom <b>e</b> r	`y
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In )	vrs. last birthday)		r1 Year   If U	nder 24 Hrs. urs Min.	8. Date of Bi (Month, D	rth	O Diet	place (State or Foreig
	Director		133-14-3314	<b>M</b> 2□ F 88	Yrs.				Nov.	28 1	920 Ne	w Jersey
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation						10d. Inside City Limits
	f sho	5	Md. Montgo	mery	Silv	er Sp	ring					1 ☐ Yes 2 X No
	r 28a-	irec	10e. Street and Number			10f. Zi	p Code			10g. Cit	tizen of What Co	untry?
	h with	Funeral Director	14400 Homecrest F	Road, #57			20906	5		U	nited St	ates
	ems ems	iner	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Dece	dent of Hispani ecify Cuban, Me	ic Origin? (Spe exican, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene, Hygiene, then "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Ϋ́F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	wii	1 🗌 Yes	2⊠No Sp	ecify:			Specify: W	nite
Ö	hour Itural	Completed by	15. Decedent's Ed		16a. Dece	dent's Us	ıa! Occupation			16b. K	and of Business/	ndustry
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212	filed with Hygiene. Ither thar ent, the N	mo.	12	O		Cle						vernment
nd	be file	Be (	17. Father's Name (First, Middle, Last)				18. [	Mother's Name				
yla	2 should be fi and Mental Fis marked of aumatic ever	6		akes	1			Caroly		itin		7:- O
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (7 Elizabeth M. Feak			•				-	or Town, State, 2 Spring	Md. 20906
	1 and Health em 27 other tr		20a. Method of Disposition	-	b. Place of Dispo cemetery, cre				ate		ocation - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Both important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Gate of			6/1	6/09	S	ilver Sr	oring, Md.
alti.	permit. Page Department of Important: If any injury or once.		21. Sign stur of Funeral sevice Licen			2. Name a	nd Address of	Facility				, , , , , , , , , , , , , , , , , , , ,
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			23a. Party. Enter the disease, or company shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not en	ter the mo	de of dying, su	ch as cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death
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4	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):							
	Hala	-	Sequentially list conditions,	b. Due to (or as a cor	sequenne of):							
	uted d ansit	min	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events									
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9 ×	ertifica ling pl		IF FEMALE:	23c. If yes, outcome pf pr	ocnanov						001.0	
Вох	eath c attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic □ Other (	pregnancy				23d. Date of de Month	Day Year
P.O.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	or doding of		,poony/					
σ,	s that ned by deta		Part II. Other significant conditions	contributing to death but no	resulting in the u	underlying	cause given in	Part I.	23e. Dic	l tobacco	use contribute to	the cause of death?
Records,	quires en sig	Completed by							10	]Yes	2 <b>/N</b> 0 3□P	robably 4 Unknow
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Vital	an: rtifica tor,	Be (	25. Was case referred to medical examiner?					Place of Deat	Check onl	one		
7	2 0 0	100 1			2 ER/Outpatie			Nursing Ho			6 ☐Other (Spe	ecify)
	hystel this cer at direc	P	1 ☐ Yes 2) No		28b. Time	OI	28c. Injury at Work?	0.77	28d. Describ	e now inj	ury occurred	
n (	ding Physici	P	27. Manner of Death  1 ★ Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) Injury	M	1 ☐ Yes	21 IIVO 1				
ision	Attending Physici death. ctor: After this cei y the funeral direc	P	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Yea	At home, farm, s	M treet, facto	1 ☐ Yes ory, office	2   NO	28f. Location	(Street a	and Number or R	ural Route Number,
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Division	the Hospital or Attending Physici in 24 hours after death. the Funeral Director: After this cen spletely filled in by the funeral direc	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only one)  27. Manner of Death 5 Pending Investigation 6 Could not be determined	(Month, Day Yea	At home, farm, soecify)	treet, facto	ory, office and at the time, on on, in my opinio	date and place, on, death occur	City or 1	ne cause e, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
Division	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death:  Within 24 hours after death:  To the Funcati Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	P	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only	(Month, Day Yea  8 28e. Place of injury - building, etc. (S)  1ysician: To the best of my niner: On the basis of exa	At home, farm, soecify)	treet, facto	ory, office	date and place, on, death occur	City or 1	ne cause e, date a	(s) and manner a	s stated. e to the cause(s)
Division		Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature the title of certifier	(Month, Day Yea	At home, farm, sopecify)  At home, farm, sopecify)  A knowledge, deamination and/or i	treet, factors, the occurrence stigation	ory, office and at the time, on on, in my opinio	date and place, on, death occur	City or 1	ne cause e, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director:  Completely filled in by the funeral director.	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only one)  27. Manner of Death 5 Pending Investigation 6 Could not be determined	(Month, Day Yea  28e. Place of injury- building, etc. (S)  nysician: To the best of my miner: On the basis of exa and manner steed.	At home, farm, sopecify)  At home, farm, sopecify)  A knowledge, deamination and/or i	th occurrenvestigati	ory, office and at the time, of on, in my opinion  9c. License nur	late and place, on, death occur	City or 1	ne cause( ie, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)

State Registrar

/ VA

29a. Certifier

29b. Signature

(Check only one)

Medicai

31. Date filed (Month, Day, Year)

of certifie

Peter Schissler, M.D. 7500 Greenway Center Drive # 430 ' Greenbelt, Md.

of person who completed cause of death (Item 23a) (Type, Print)

1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 22780

29d. Date signed (Month, Day, Year)

June 12,2009

DHMH 17 Rev 1/2001

the Hospital

Amend #10e, 18, 19b per FH PGC 6/17/09 HH **Physician** /Medical Examiner Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director D.C. 3307 Funeral þ Completed Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 20:00 2009 JUNE 11, ODESSA P. FORDE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Months Days Hours 1 □ M 2 □ X F 3/13/1920 Barbados, WI 89 122-34-7907 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1X1Yes 2 □ No Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Gainesville United States St. 20020 S.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 X No 3 ☐ Widowed 4 🖾 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Retail Employee 18. Mother's Name (First, Middle, Maiden Surname) Evangeline Kellman 17. Father's Name (First, Middle, Last) Robert R. Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3307 Gainsville St. S.E. Washington, D.C. 19a. Informant's Name/Relationship (Type. Print) Daughter 20020 Margaret Forde-Olaghere 20c. Location - City or Town, State West 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 6/27/2009 St. Michael, St. Judes Cemetery Indies 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Literisee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part I. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heroschoopic **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (unas a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 DNo 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Hinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner eath 28a. Date of Injury 28c. Injury at Work? Injury (Month, Day Year) 1 - atural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 60 los 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD 31 Universey 8 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8 2009 Addie Jane Grimmer June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Salisburg
If Under 1 Year If Under 24 Hrs. Wicomico Salisburg Rehabilitation Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. lest birtho Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 3-27-1924 7. Age (In yrs. ast birthday) **Funeral** Hours Days Months 1 ☐ M 2 🗶 F 85 MD 215-22-1707 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Medical Examinations to be notified at 1 XYes 2 No Directo MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21804 200 Civic Avenue by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married しなれる (Jrimmer) Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ John Parks <u>Minnie Lee Corbett</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2015 Beer Ridge Rd, Baltimore, MD 21222 Jane Ann Rogers/Daughter 20b. Place of Disposition Name of cemetery, crematory or other priare 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dover, DE 6-12-2009 Direct Crematory 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 917 W. Isabella St Signa of Fineral Service Licenses Bennie Smith Fun Home Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart future. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ear **Physician** 00 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consecuence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 □Yes 2 ♠No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

William H-Robins, M.D. 200 Civic 32. Registrar's Signature Year) 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salisburg

State of Maryland / Department of Health and Mental Hygiene 2009

20724

					Certificate of	Death		Reg. No.		
	0	1. Decedent's Name (First, Middle, La	est)				2. Dete of D Month	eeth Dey	Year	3. Time of Death
4	Physician /Medical	ELIJAH GILI	MORE				06/	10/09		5:10 Pm
	Examiner	4a Fecility Neme (If not institution, gir				4b. City, Town	n, or Location of Dea	th 4c. County	of Deeth	
		Hartley Hall Nu	rsing Home				moke	Word	ester	
	Funeral Director		3.7	72 (In yrs. lest birth	rs. If Under 1 Year Months Days		irth Dev. <i>Year)</i> 2/36	Year) 9. Birthplace (State or Foreign Country) SC		
	2	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								d. Inside City Limits
	• Manylar • I show the d at	MD 10b. County Worces	ter	Poco:	_				10	1 CYes 2 No
	or 28	10e. Street end Number			10f. Zip Code		-	10g. Citizen of	What Countr	у?
	th wi	1210 Market St.			21	851		USA		
0	filed within 72 hours after death with the Maryland Hygiane. ther than "naturel", or flems 23a or 28e-f show ont, the Medical Exeminer must be notified at one.  Completed by Funeral Director	11. Maritel Status 1 ☑Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 Yes 2 3 N If Yes, Give		U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 □ No Specify:  14. Race - American Indian, Black, White, etc.  Specify: Black					
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21215-0020	ed within 72 hours ygiane. or than "naturel", it, the Medical Exe Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)		Decedent's Usual Occu Give kind of work don	e during most o	of working	16b. Kind of B	usiness/Indu	istry
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Baltimore,	parmit. Pages Department of Important: If it any Injury or o	gnature of Full 24 is List	lisee		22. Name and Add					
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5	Physician: this cartific ral director.	examiner?	Hospital:	nt 2 ER/Out	patient 3 DOA	/	sing Home 5 ☐ Re		her /Snecify	)
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o	ding th. Afte func	1 Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey	<i>Year)</i> In		fork? ∐Yes 2∐No	D			
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$\frac{5}{2}$	lal or Attending P rs after death. al Director: After t led in by the funers Certification:	4 Homicide	building, etc	City or T	own, State)					
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	ne Hospi n 24 hound ne Funer pletaly fill edical		miner: On the basis of and manner ste	examination end						
	within 3	29b. Signature and title of certifier	1-1:		29c. Lice	nse number		29d. Date signe	ed (Month, L	Day, Year)
	► \$ ⊢ ŏ	<b>&gt;</b> 8	ittpul N	10	Do	06217	72	6/1	1/200	99
	12/	30. Name and address of person who	completed series of di	ath (Itam 22a) /						
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	State	31. Date filed (Month, Day, Year)	32/Registra	r's Signatyre	(	, 01.	. 000171			
	Registrar	JUN 11 20	ng De Document	A	parle					
12		9013 8 8 20	40		7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2009 **Physician** 10:46 AM BETTYE 21 June JOAN HERRELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🖫 F Director April 13, 1939 Maryland | 216-56-4506 Usual Residence of Decedent the Maryland 10d. Inside City Limits show 10a, State 10b. County 10c. City. Town or Location and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Maryland Frederick Jefferson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 3819 Jefferson Pike 21755 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes. Give Specify. Specify: White Ď 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Electric Component Manufactur. Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumatic ပ Arthur Thomas Dill Margaret Maude Duvall Dill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 9310 Garis Shop Road, Hagerstown, Maryland 21740 James R. Herell, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial Cardens June 26, 4 □ Donation 5 □ Other (Specify) Frederick, Maryland Keeney and Bastord PA Funeral Home 21. Signature of Funeral Service License MO1473 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, a com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Widowarysa In faction **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Hopeadensin sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) rate has been signed by the a page 2 should be detached to 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes ours after death.

eral Director: After this certific: filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes P 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Tyes 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

8

State Registrar D16939

MP 300 South Church Street, PO Box 20, Middletown, Maryland 21769

June 22, 2009

(M -3 B)

Behre,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sgnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Dous HUGHBS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M XXF Months Days 578-54-9933 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Beltsville Maryland Prince Georges Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with U.S.A. 20705 11226 Cherry Hill Road, Unit 202 Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes ★★No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: White 2 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Potter Roscoe Perkins 20705 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11226 Cherry Hill Rd., Unit 202, Beltsville, MD of Health a item 27 is Mr. Mark C. Hughes, son 20a. Method of Disposition Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pleasant Grove Cemetery June 27, 2009 Mountain City, TN permit, Pages Department of Important: If it any Injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fameral Service I censee 22. National Home 22. National Participas Funeral Home JE 106 East Church St., Frederick, MD 21701 M00255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit Cause (Disass or injur that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 □Yes 2 DMo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 Mo 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Hatural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063703 luses out lan, TANONIN BARU, WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYNSHELH WAR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 29 20

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04902 2009 20727 State of Maryland / Department of Health and Mental Hygiene Jonathan Robert Henderson 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 21, 2009 0311 hrs **Medical Examiner** JONATHAN ROBERT HENDERSON 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Woodlawn **Baltimore County** Westbound on 1-70 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. **Se**x 7. Age (In yrs. last birthday) Funeral Hours Months Days APR.17,1989 1X M 2 F Director 216-25-7977 20 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location IN 1 X Yes 2 No LA PLATA MD. CHARLES or 28a-f show hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1414 REDWOOD CIRCLE 20646 U.S.A. 14, Race - American Indian. Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 11 Marital Status 12 Was Decedent Ever in U.S. items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 2 X No Yes Specify: WHITE 1 Yes 2 X No specify: 3 Widowed 4 Divorced f Yes. Give Year \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 h nent of Health and Mental Hygiene. ant: If item 27 is marked other than "n or other traumatic event, the Medical E ELECTRICIAN ELECTRIC CO. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES HARRELL HENDERSON, JR. MARY CHRISTINE CULVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1414 REDWOOD CIRCLE PLATA MD 20646

20c. Location - City or Town, State MARY C. TOMAN-MOTHER LA PLATA, MD Baltimore, Permit. Pages I and 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State METROPOLITAN CREMATORY 6-23-09 ALEX., VA. Donation 5 Other Specify. M00479 RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licenses PLATA, MD. 20646 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Retween Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Year 3 Ectopic pregnancy Month 1 Live birth Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t be detache Records, P.O. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available peen autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No 1 V Yes certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 Yes funeral 28a. Date of Injury (Month, Day, Year) FOUND: 28d Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Pedestrian struck by auto FOUND Natural 1 Yes 2 ✔ No 5 Pending within 24 hours after death To the Funeral Director: Jun 21, 2009 0307 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Westbound on I-70, Woodlawn, MD determined (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

OCME

**Medical** 

State Registra

29b. Signature and title of certifie

Mary G. Ripple MD.

DHMH 17 Rev 1/2001 OCME 2006

and manner stated

Deputy Chief Medical Examiner

Registrar's Signature

address of person who completed cause of death (Item 23a)

2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 21, 2009

# Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

physician ar s the burial-to Box 68760, P.0. Division of Vital Records, certificate this After t

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June June **Physician** 9:45 PM Francis Leo Hartman /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 7/17/1943 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F MD 216-42-7095 65 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes ZXNo Director Howard Mt. Airy MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21771 17526 Woodcamp Rd. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? or items, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1966-79 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: ð White 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NSA 5+ Security Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isaac Myrl Hartman Helen Louise Meyers ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 17526 Woodcamp Rd., Mt. Airy, MD 21771 Laura Lee Hartman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Winfield, MD South Carroll Crematory 6/11/09 4 □ Donation 5 □ Other (Specify) 21. Sighan re of Funeral Service Licence 22 Name and Address of Facility Burrier-Oueen Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of beart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) THEROSCIEVOTIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≽</u> 2No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **2 N**O 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 □ No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 Natural 5 Pending 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifi-29c. License number 5 WJL 6/10/2009 MDD 37197 18+1VA treet, Frederick MD 21701 Kohi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20729

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day JUNE 2 Year Physician 14200 6:00 AM MARY JO HAYDEN /Medical City, Town, or Location of Death %oµnty of Death Facility Name (If not institution, give street and number Examiner VII) DO. Birthplace (State or Foreign Country)
 JAPAN if Unde 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday **Funeral** Days Min. Months Hours 1 □ M 2 😿 F NOVEMBER 30, 1930 78 416-64-6557 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygleina. Department if Hean is marked byte than "natural" or Items 23a or 28a-1 shou Important; If Item or other transted other than "natural" or Items 23a or 28a-1 shou any injury or other traumatic event. The Medical Example is must be muffled at 1 ☐ Yes 2 No Director WHITE PLAINS CHARLES MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 20695 4068 HANSON ROAD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: ASIAN ₽ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT ANALYTICAL CHEMIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YOUNG SUN KIM YUSUNORI KAWAMURA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4068 HANSON ROAD, WHITE PLAINS, MARYLAND 20695 DAVID L. HAYDEN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pages 1 CHARLOTTE HALL, MARYLAND BRINSFIELD-ECHOLS CREMATORY JUNE 15,2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Fugueral Service Licensee

LADIA C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death NEUMONIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) CANCEIL **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 □ Yes icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To this 27. Ma r of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D67934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DB 1 C-MARTIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 2:45 AM **Physician** Har bava VIS 2000 JUNI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timor dical a 9. Birthplace (State or Foreign If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Jan. 1, 5. Social Security Number 6. Sex **Funeral** Months Days 1957 Pennsylvania 1 M 2 □ F 220-62-1695 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State in than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at 1 Yes 2 No Director Frederick Walkersville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21793 107 Glade Blvd. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Maxical Examiner must any injury or other traumatic event, the Maxical Examiner must applies. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) House Painting Painter 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joan Blizzard Martin Harbaugh, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 107 Glade Blvd. Walkersville, MD 21793 Tina Harbaugh / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June I6, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland 2009 4 ☐ Donation 5 ☐ O#rer (Specify) Resthaven Crematory 21. Signature of Funeral Service Lizensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death rications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or or shock, or heart failure. List of Immediate Car & (Final disease or cor dition resulting in death) **Physician** Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dura to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 21 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ap this certificate has buildirector, page 2 sh 2 | No 2 🗆 No After this certificate 1 □ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 19 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To I Director: After this of in by the funeral d 27. Many r of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 5 ☐ Pending investigation (Month, Day, Year) 1 ☐Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined within 24 hours after To the Funeral Dire 4 Homicide completely filled Medical ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3

State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

ORIGINAL

St Bultimore, Mary

completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

USHUW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29 Day Month 05 1:00A M 2009 Felicitas Lugue Hagan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Kensington Nursing & Rehab Kensington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Hours 1 □ M 2 😾 F 464-44-0283 83 11/16/1925 Phillipines Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No Montgomery Kensington 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20895 United States 3000 McComas Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Phillipino 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Cosmetology Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel Lugue Perpetua Lampa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brian L. Kass/Guardian 1050 17th Street, NW, Ste.1100 Washington, DC 20036 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/2009 Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Spegify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Services 7400 Georgia Avenue, NW, Washington, DC 20012 nances 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

**Physician** /Medical Examiner

Department of Health ar Important: If item 27 is any Injury or other trauonce.

**Physician** 

/Medical

Director

Funeral

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Completed

Be

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MD

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, It. Mental Exercitive count to retired any or other traumatic event, It.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner attending physician and for use as the burial-tran is been signed by the should be detached 2 Completed s certificate has be irector, page 2 sl To the Hospital or Attending Physician: within 24 hours after death. : After this certific tuneral director, Be Certification: To he Funeral Director: Af

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):						
	, d						
if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of		oic pregnancy (specify)	23	3d. Date of delivery Month Day Year			
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?  Ño 3☐ Probably 4☐ Unknown			
			24a. Was an autopsy performed 2, 1 □ Yes 2 ♣ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ➡ Yo			
25. Was case referred to medical		26. Place of Death	(Check only one)				
examiner? 1 ☐ Yes 2 万No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hor	ne 5 Residence 6	Other (Specify)			
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28d. Describe how injury				
1 Yes 2 7No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	etory, office 2	28f. Location (Street and City or Town, State)	Number or Rural Route Number,			
29a Certifier 197 Certifying Ph	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investiga and manner stated.	rred at the time, date and place, ation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)			
29h Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year)					

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State Registrar 29b, Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

within 2.

Dr. Truong Bao, 9715 Medical Center Drive, Ste. 201, Rockville, MD

	1 - State Registrar		of Maryla		ertificat					Reg. I	00	09	20732
an	Decedent's Name (First, Midd     Ayed Nassir								2. Date of D Month		Day	Year	3. Time of Death
al er	4a. Facility Name (If not institution	Haddad on, give street and n	umber)	·	4b. City,	Town, or	Location	of Death	June		, 200 4c. County		1.12 p
	Holy Cross Hos	pital					Spri	_			Mont		
	5. Social Security Number 545–49–5980	6. Sex 1 M 2 □ F	7. Age (In yrs	s. last birthd Yrs	Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, L June	Jay, Yea			hplace (State or Foreign untry) dan
	Usual Residence of Decedent  10a, State 10b. County	у	10c. C	ity, Town or	Location								10d. Inside City Limits
Director	Maryland Me	ontgomery		Silve	er Spri	ing							1 □ Yes 2 X No
2 2	10e. Street and Number  18 Homecrest	Court			10f. Zip	Code 2090	26			10g.	Citizen of		untry?
פום	11. Marital Status	12. Was De	cedent Ever in l	J.S. 1	3. Was Deced	dent of H	ispanic Or	rigin? (Sp	ecify Yes or N	lo-		ce - Ame	rican Indian,
5	1 ☐ Never Married 2 Mai 3 ☐ Widowed 4 ☐ Divorced	If Yes. G	: 2 <b>K</b> ]No 3ive		If Yes, spec	2	Specify		Rican, etc.)		Special Special	ick, White	white
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	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		m State Ga		crematory`or o Heaven			y y	ine 16 2009		llver	Spr	ing,Marylan
	21. Signature of Funeral Service				22 Name an	d Addre	ss of Facil	Yins	Funera				ng, MD 2090
	Lew	una	MA	v_							lver	Spri	ng, MD 2090 Approximate
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State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 0214 M 2009 Charles Edward Hooper /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HICOMICO SAISSAN TENINSUM If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Months Days 1⊠M 2□F 6-24-1943 Director 214-42-8926 65 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No by Funeral Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Execution of the property. 21804 USA 828 S. Schumaker Drive, Apt. 102 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1964— If Yes, Give Year or Dates: 1970 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store 12 Customer Service Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence CoxWilliam Hooper, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21804 19a. Informant's Name/Relationship (Type. Print) 828 S. Schumaker Drive, Apt. 102, Salisbury, MD Linda Bounds - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State I ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gds; 6-15-2009 Hebron, Maryland 4 Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Pin Enter the disease, or complicate fine that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only no cause on each line. 705 E. Main Street, Salisbury, Maryland 21804 Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or any or this page) Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. tor: After this certificate has been signed by the the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. DM 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed 2 No 1 □Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature of cer 11/09 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. hris Snyder SALisburi Md, 21801

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**JUN 15** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Hetherington Margie Beatrice Farmer JUNE 10 4c. County of Death

**Physician** /Medical Examiner

446 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Vicanio SALISBUM 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 227-64-6682 1 □ M 2 🖫 F 89 10/13/1919 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment out to profit of 1 XYes 2 No Wicomico Salisbury Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 1109 S. Schumaker Dr., Apt. 210 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 ∐Yes 2 ⊠ No Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify. If Yes, Give Year or Dates white Completed by Specify: 3 X Widowed 4 □ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Smith Dale Farmer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 3305 Blue Heron Way, Eden, MD 21822 William S. Hetherington/son 20b. Place of Disposition (Name of cemetery, crematory or other place Woodlawn Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/09 Norfolk, VA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee <sup>22</sup> Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CESP Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) MO e WS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pred ant in the past 12 months?

1 Yes 2 W No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title, D36783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

CARROLL

100 E

Registrar's Signature

MD

St. SAlisbury ma 21801

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Пау Year Month **Physician** 11:12a M Frances V. Jacobsen June 08 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville 11902 Parklawn Place 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 6. Sex Funeral Hours Months Days 1 M 2 X F New York December 02,1926 128-14-6918 Director 82 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evandams and be mailted at 1 XYes 2 ☐ No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20852 11902 Parklawn Place Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 🔽 If Yes, Give Year or Dates: 2 🙀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify 2 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Algeo 0 Louis Hansen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4111 Knowles Avenue, Kensington, Maryland 20895 Carla Malick - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Pemoval from State Ò Arlington National Cemetery 8/03/2009 Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Juneral Pervice Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Emer the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Fin I disease or addition resulting in death) **Physician** 1 year Hypertension /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the second of the second cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □Yes 2 🖾 No Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> High blood pressure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Nursing Residence} \) 6 \( \text{Other (Specify)} \) 1∐Yes 2🎦 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

le Funeral Director: A
bletely filled in by the fi 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D62063 June 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janel Wyatt,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mon

M.D.

Registrar's Signature

14207 Park Center Drive #102; Laurel, MD 20707

			For State Registrar	State of	of Marylar		artment <i>tificate</i>			ind M		Reg. No.	009	20736
	Physici	an	1. Decedent's Name (First, Midd								2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Donetha	Jenkins						( Danih	June 2		ounty of Deat	12:28 P M
4	Examin	er	4a. Facility Name (If not institution		imber)		4b. City, To							
	Europel		Holy Cross H 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Silve If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birt	h	tgomer 9. Birti	hplace (State or Foreign
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	shov	៦		gomery		ver Sp								1 ☐ Yes 2 ☐ No
	28a-1	rect	10e. Street and Number	30mer y	. 511	ver bp	101. Zip C	Code				10g. Citiz	en of What Co	untry?
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	ems 2	ner	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White	
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21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show the Modical Examinator ust be notified at	ed p		d Year or I	Dates:	16a, Dece	dent's Usual	Occupa	tion			16b. Kin	d of Business/	îndustry
75	nin 72 n "ne Medic	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	(Give life.	kind of work DO NOT use	done d retired)	u <i>ring</i> most	t of work	ing			
212	d with	Completed	Elementary/Goodingary (G-12)	4 yea		Reta	i1						vate	
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle	, Last)							e (First, Middle,		Su <i>ma</i> me)	
yla	d Men narke	7	Dennis Lewis  19a. Informant's Name/Relation	ship (Tuno Brint)		10h Maili	ng Address (	(Street a			ie Jenki al Route Numb		Town State 2	Zip Code)
Maryland	id 2 sl Ith an 27 Is r treur		Mack M. Jenkir								chellvi			
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat rust be notified at once.		20a. Method of Disposition		20b.	 Place of Dispo cemetery, crea	sition (Name	e of her place	9)		Date	20c. Loc	ation - City or	Town, State
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Vital		e Co	25. Was case referred to media	nion, C	as mos	romy	Stat	es	26. Place	of Dear	1 ☐ Yes	2 No one)	1 L Yes	s 2 No
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Division	Dir	Certification;		mined 288. Plat	ce of Injury - At I ding, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory,	, office			City or To	wn, State,	)	urai riodio rainioer,
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		ate	30. Name and address of person NURUL CHOU  31. Date filed (Month, Day, Yat	UHURY 32	Registrar's 2 ion	J 2/6	DINO	DR	ive	134	KIONS	V ( but	, , ,	7 000
4	Regist		JUN 1 8 20	US Peron	P.	gare								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0727 M Seonggeun Jeon /Medical 4c. County of Death Examiner Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Kegional Medical ( DICOMICE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral 8. Date of Birth (Month, Day, Year) SeouI Months Hours Min 1**X** M 2□ F Korea Director 85 7-1-1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 1 XYes 2 □ No Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 1018 Adams Ave, Apt 2D Korea 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Korean 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Laborer Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yongqi Jeon Myunqva Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1018 Adams Ave, Apt 2D, Salisbury, MD 21804 By Ung Ho Joun/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-16-2009 Dover, DE Crematory, 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Calidhury MD 219 Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) TYes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred v To the Hospital or within 24 hours after death.

To the Funeral Director: After a funeral principle of the funeral prin 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number OME 6/15/09. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snyder hris 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar JUN 15 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jun 17, 2009 **Physician** 6:29pm <sup>™</sup> Klosterman Florence Marv /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany The Country House Residence Cumberland 8. Date of Birth (Month, Day, Apr 14, 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days 215-12-2406 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 10a, State 1 √Yes 2 No Allegany Cumberland MD Director 10g. Citizen of What Country? 10e. Street and Number 21502 USA 474 Fort Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify white Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Fazenbaker Monahan John Monahan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
614 Montgomery Avenue Cumberland MD 19a. Informant's Name/Relationship (Type. Print)
Debra Vinci MD 21502 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition St. Mary's Cemetery 1 Burial 2 Cremation 3 Removal from State 6/22/2009 MD Cumberland 4 ☐ Donation 5 ☐ Øther (Specify) 22. Name and Addressio Funetal Home, PA 21. Signatur- f Funer Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an autopsy performed? 1 Yes 2 KNo 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 St Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No 1 Inpatient Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, 🖔 attending pl cate has been signed by the page 2 should be detached this After t

To the Hospital within 24 hours after death.

To the Funeral Director; After the funeral Director of the funeral by the funeral branch of the funeral bran

**Funeral** 

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examinat must be netitived at

Department of Important; If it any injury or conce.

**Physician** /Medical

Baltimore, Maryland 21215-0036

the Maryland

1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Loui	(Check only one)	2☐ Medical Ex	
29b.	Signature an	d title of certifier	11

JUN 29 2009

3 Suicide

29a Certifier

4 Homicide

6 □ Could not be

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SETON DR. CUMBARIA 31. Date filed (Month, Day, Year)

State Registrar

6

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04566 2009 20739 State of Maryland / Department of Health and Mental Hygiene John Preston Kearns Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 8, 2009 1428 hrs Medical Examiner PRESTON JOHN KEARNS c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Bethesda Suburban Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Hours Min Months Days Director 048-18-5447 Feb. 1, 1922 Danville, PA 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Maryland Montgomery Silver Spring 28a-f shov Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, If I fire a 72 is marked other than "natural", or items 23a or 28a-f sho ar other traumatic event, the Medical Examiner must be mained. 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 12005 Kerwood Road 20904 U.S.A. ä 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 2 X Married Never Married Yes White Specify: Yes 2 X No specify: If Yes. Give Year Divorced <u>8</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Johns Hopkins Applied Elementary/Secondary (0-12) 21215-0036 4 Mechanical Engineer Physics Laboratory 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret McCormick Charles Maxwell Kearns, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 12752 Turquoise Terrace, Silver Spring, MD 20904 John S. Kearns, Esq./Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Cremation 3 X Removal from State 1 X Burial 2 06/17/2009 Beavertown, PA Cedar Hill Cemetery Donation 5 Other Specify 5 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. Signature of Funeral Service Licer see 11800 New Hampshire Ave, Silver Spring, MD 20904 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I, Enter **Physician** Between Onset and failure. List only one cause on each line Death 'Medical a. Multiple Injuries Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and ηνsician/Medical UNPENDED AMENDED the attending physician led for use as the burial 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box requires that the death 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 Unknown þ Δ. Completed Records. 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? certificate has 1 V Yes ✓ Yes 2 26.Place of Death (Check only one 25. Was case referred to medical or Attending Physician: Be of Vital Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 Yes 28a. Date of Injury (Month, Day,Year) Jun 8, 2009 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject struck by vehicle Certification: 1330 hrs Yes 2 V No Natural Division Pending death. the Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 10313 Georgia Avenue, Silver Spring, MD within 24 hours a To the Funeral I determined (Specify) Parking Lot the Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

10

29b

Signature and title of certifie

Laron Locke MD 31. Date filed (Month, Dex Ye

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 9, 2009

livery 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

amend #17 Per Fig. 6893 Mary 2409 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician Ам 2009 6 Helen /Medical Lorraine 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3 West - East Street Delmar Wicomico Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min Hours 1 □ M 2 🛛 F Yrs Director 577-52-4632 5-24-1938 Washington, D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show injury or other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Funeral Director MD Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 West - East Street 21875 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumarin exercises. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 27 No Specify: þ If Yes, Give Year or Dates Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Torreyson Franklin ပ O'Donnell Thelma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annette Waters - Daugther 3 West- East Street, Delmar, Maryland 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏻 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 6-12-2009 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Por 1. Enter the disease of complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final ul disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as S autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No after death Director: 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft Jo the Funeral Di completely filled in 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu Wilme and address of Ferson who completed care of death (Item 23a) (Type, Print) PO Box 17.33 Salishi Hospice reller WW 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 0915 Helen Edith Lebo /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Vicamica eninswa Regional Medical Center 8. Date of Birth (Month, Day, Year) 10/19/1936 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🛛 F 202-42-5837 PA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County Department of Health and Mental Hygiene, important; or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show alvay no other traumatic event, Ite Medical Exanitration of the traumatic event, Ite Medical Exanitration of the profession  ☐Yes 2 X No Funeral Director MD Somerset Eden 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21822 USA 14410 Dogwood Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X☐
If Yes, Give
Year or Dates: 2**X**] No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify Specify: <u>≽</u> 3 Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Wentz Alva Richcreek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9705 Stephen Decatur Hwy., Ocean City, MD 21842 Robert B. Lebo / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park | 6/17/2009 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUD 544a15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 XNo 1∐Yes 2∐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this of etely filled in by the funeral dire 1 Yes 2 No 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

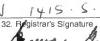
Division of Vital Records, P.O. Box 68760, within 24 hor To the Fune completely f

> BAI State Registrar

NATESAN DR. USHA 31. Date filed (Month, Day, Year) JUN 1 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



DIVISION ST

29c. License number

SALISBURY

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Frank F.Lipford 8:00 p 14 2009 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 440 Muddy Lane Elkton Cecil If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Hours 1 M 2 □ F Months Days 215-34-1789 70 August 30, 1938 TNDirector Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD Elkton Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 440 Muddy Lane 21921 **USA** Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Material Handler General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dennis Lipford Ethel Lewis Budd 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Lipford/Wife 440 Muddy Lane, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD Cherry Hill Cemetery June 18, 2009 22. Name and Address of Facility 21. Signature of Funeral Service Censee Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cuse (Final disease or condition resulting in death) Physician /Medical Examiner VVOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a d be detached f 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P ... II. other significant conclions contributing of death but not resulting in the underlying cause given in Part 1. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 20 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 2 vitin 24 hours after death.

To the Funeral Director: After this commoletely filled in by the funeral di 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

State Registrar pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 0943 AM **Physician** )unc 18 2009 harles /Medical b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 🗙 M 2 🗆 F November 22, 1982 Maryland 218-02-8592 26 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10h County Examiner must be notified at 1 X Yes 2 No Frederick Frederick Director Maryland 28a-f 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö United States 21701 1210 Staley Avenue or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Yes Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Custodial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Harmon Charles Robert Morgan II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1210 Staley Avenue, Frederick, Maryland 21701 Charles Robert Morgan II / Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Resthaven Memorial Gardens June 23, 2009 1 XBurial 2 Cremation 3 Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funeral 106 East Church Street, Frederick, Maryland 21701 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or neart failure. List only one cause on each line. Immediate Cause (Final 24 Lours **Physician** tractory disease or condition resulting in death) /Medical for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Jerry in Cause (Disease or injury that initiated events resulting in death) Last Examiner Aciste The law requires that the death certificate be executed Lymphou burial-trar and Due to (or as a consequence Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 

Ectopic pregnancy Year in the past 12 months? Month Dav be detached for Pregnant at time of death 5 Other (specify) 2 No Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 TYes 2 No certificate or Attending Physician: 26. Place of Death (Check only one) completely filled in by the funeral director, Be 25. Was case referred to medical xaminer? Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 🗌 DOA မ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury s after death. I Director: After the Certification: 5 Pending investigation (Month, Day 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours are To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Hair hunles . Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** D:00A M Miller Charles Jr. JUNE 21, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany 229 Baltimore Ave. Apt. 410 Cumberland 8. Date of Birth (Month, Day, Year) Jun 18, 1940 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Gountry) MD **Funeral** Months Days Hours 1 □ xM 2 □ F 212-38-5262 69 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire Z7 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. M. Jical Experiment. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count MD Allegany Cumberland Be Completed by Funeral Director 1 □ ¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 229 Baltimore Avenue Apt. 410 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Sergeant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles E. Miller, Sr. unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
229 Baltimore Ave Apt. Cumberland MD 19a. Informant's Name/Relationship (Type. Print) Deloris Miller wife 229 Baltimore Ave Apt. MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 6/24/2009 MD Flintstone 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Paral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on the use on each line. Approximate Interval Between Onset and Death Immediate Cause (rinal disease or condition resulting in death) COPD **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 | Yes 2 □ DNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 100064 21502 who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/200

State

31. Date filed

IND

Division of Vital Records,

Westminster, MD 21158 20c. Location - City or Town, State Hampstead, MD Pritts Tunerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death To the Hospital or Attending Physician: The law requires that the death certificate be executed 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes Other: 4 Kenny Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After s after deau. ral Director: Aftr 5 Pending investigation 1 Natural 1 🗆 Yes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number WJL completed gause of death (Item 23a), (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Registrar DHMH 17 Rev 1/2001

State

FRANCIS KHOO 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Ceneur

VE, WESTMWSTER, MD 2115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9 ENEUA TUNE 200 MI-NIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Months Days Hours Min. 8 4 Yrs. 579-28-8643 W۷ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ir than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2X No Director MD Worcester Berlin 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21811 19 White Crane Dr. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣 No Specify: Be Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Mae Davis John W. Tester ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19 White Crane Dr., Berlin, MD 21811 Stephen E. Matthews, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 6/15/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Burbage Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence f): Severe dev Examiner demontin Sequentially list or dittons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine pertension Due to o as a consequence of): ing physician ar s as the burial-t Physician/Medical P.O. Box IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy signed by the atter I be detached for u 5 Other (specify) 1 □Yes 2 □No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Januan III 1052312 12 JUN 2009 and address of person who completed cause of death (Item 23a), (Type, Print) Drive Berlin, MD 21811 Healthway Stegory Was 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 5 2009

DOD: 6/12/09

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Type of Time in Black indonsite line. Endate the copies to
State of Maryland / Department of Health and Mental Hygie
Certificate of Death

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Funeral		5. Social Security N	umber	6. Sex	7. Age (In yr	s. last birtho	ay)	If Under 1	Year I	f Under 2	24Hrs.	8. Date of Bir	th(MM/E				State or
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imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygien and a threath and Mental Hygien than "matural", or items 23a or 28a-f sho or other traumatic event, the Medical Tx miner must be notified at once or other traumatic event, the Medical Tx miner must be notified at once.		4 Donation 5					•		thod			etery	Lav	tone	evi 1	م11	MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Median	9	21. Signature of Fu	neral Service	Licensee		aycom	22. Na	ame and Ad	dress of	Facility	Mo1	eswort	h-Wi	111iai	ms I	Tune	ral Home
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ffcate be executed g physician and the burial - transit	/Medical												1			<u> </u>	
376 ficate g phy s the		IF FEMALE: 23b. Was decedent	pregnant in th		yes, outcome of p Live birth		Fot	al death	3	Ectopic p	reanan	CV.		d. Date of one of the distribution of the dist		o Day	Year
c 68	cial	past 12 months	1?		Pregnant at time of			er (Specify		_0,0p.0 p	57 0 g. 1 a. 1 .	-,				-,	
Box 68760, e death certificate be the attending physic ed for use as the burn	Physiciar	1 Yes 2 N	No 9 Uni	known g l	Jnknown		Ou I	(0)00)	<i>'</i>								
Records, P.O. Box 68760,  The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Ph	Part II. Other signi	ficant condit	ions contribut	ting to death but n	ot resulting	in the u	nderlying ca	use give	n in Part	I.	23e. Did	tobacco	use contrib	bute to	the caus	se of death?
Division of Vital Records, P.O. ra or Attending Physician: The law requires that th ars after death.  The Intercort After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by											1 Ye	s 2 🗸	<b>^</b> No 3	Prob	ably 4	Unknown
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tal Records, cian: The law requir certificate has been s ector, page 2 should	ပ္ပ						_					1 Yes	2 N	lo 1	Y	s	2 No
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ivis or A after Dire	tific	3 Suicide		id not be	Place of Injury -	At home, far	m, stree	t, factory, of	ffice build	ding, etc.		or Town.	State)				te Number, City
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this centif completely filled in by the funeral director,	Certification:	4 Homicide	dete	rmined (Sp	ecify) Local S	treet					5	000 Block S	Sydney	Road, Mo	ount A	iry Parl	k, MD
e Hos 124 h e Fur etely		29a. Certifier (Check only			e best of my know												·(a)
To the within 2 To the complet	Medical	one) 2 🗸		and man	asis of examination	on and/or in	/estigati	on, in my of	pinion, ae	eath occu	urred at	the time, date					
	Σ	29b. Signature and	title of certific	er .				29c. L	icense n	umber			29d.	Date signe	ed (Mo	nth, Day	v, Year)
		Warys	inte 1	me UKn	M				D.C.M.I	E.			Jun	ie 13, 20	009		
26		30. Name and addr	ess of persor	who completed	cause of death (	Item 23a)						-					
B		Margarita K	orell MD.	Assistant	Medical Exa	niner	111 Pe	enn Stree	et, Balti	imore,	MD 2	1201					
S	tate	31. Date filed (Moni			Registrar's Sig	nature	1										
Regis	trar		IN 15	2009 J	Breva	A. 1	par										
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Ardelle Madison June 8, 2009 7:25pM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fulton Howard Astoria House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 92 vre 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2**%** F 577-28-9416 Yrs. Wasdington DC Aug. 17, 1916 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at MD Prince Georges Lanham 1XXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 9885 Greenbelt Road apt.#225 10f. Zip Code **20706** United States 23a or death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. items ; 11. Marital Status a filed within 72 hours after Il Hygiene. other than "natural", or ite 1X Never Married 2 Married 0 Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 12th Elementary/Secondary (0-12) Dept. of Labor Supervisor or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event once. Be William J. Madison Rossie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5337 Brook Way, Columbia, MD 21044 Dianne Μ. Davis/ niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/2009 Landover, MD Harmony Mem. Park \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses Georgia, Avenue, NW, Washington DC 20012 Undre 7400 no noss 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Severe Peripheral Vascular Disease Sequentially list conditions, if any, beauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Box 68760 Physiclan/Medlcai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 2 No 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ director, page 2 should be 1 ☐ Yes 2 Ho 3 ☐ Probably 4 ☐Unknown Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 🗌 Yes 2 **X**No 3 DOA this 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After To the Hospital or Attending 5 Pending investigation 1 🖪 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D30641 June 9, 2009 aunt 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi, MD 201-109 Back River Neck Rd., Baltimore, MD 21221 31. Date filed (Month) 32. Rigistrar's Signature State 5 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12 Day 2009 Year June **Physician** 6:15A M MOORMAN Levi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Hyattsville Thomas More Nursing Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Min. 236 26 1706 87 9/22/1921 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Experience ust be notified at 1X Yes 2 No Director D.C. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20017 Funeral 5019 13th Street, N.E. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give Year or Dates: 1941 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ▼No Specify: Specify: Black ò 72 hours 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 12 should be filed with and Mental Hygie 7 is marked other the 3vrs 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other trainment Daisy Lee Moorman ပ Junius 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5019 13th Street, NE, Washington D.C. Dorothy Moorman,Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 6/18/2009 Laural, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hall Brothers Funeral Home 21. Signature of Funeral Service License 621 Flo<u>rida Avenue, NW, Washington DC</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final otic Cardiovascular Disease **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list or ultions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last reliable list every little as Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy or Month Day Year 5 Other (specify) P.0. ∃Yes 2 □No ed by the detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ HAKKINSON'S DISERSE Dementiq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Munie Kidne 24a. Was an autopsy performe Cenebral infanction 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes မ 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🚾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier VEENSBURY Rd HEATTS VIlle MD 20781 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State	State of Mary		artment of I rtificate of		vientai Hy	/giene Reg. No.	onno	20751		
			Registrar  1. Decedent's Name (First, Middle, Las	t)		inouto or	204	2. Date of De		2000	3. Time of Death		
F	hysici	an			BURY			Month	Day 08	Year 2009	7:52 A M		
•	/Medic		4a. Facility Name (If not institution, give		DOKT	4h City Town o	r Location of Death	June		ounty of Death	7.32 R		
No.	Examin	er							Montgomery				
edi:			Holy Cross Hospi  5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Bi (Month, D		9. Birthp	place (State or Foreign		
	uneral rector			⊠м 2□ F 5		Months Days	Hours Min.	Aug.	ay, <i>Year)</i> 2 <b>9.</b> 19	54 Sier	ra Leone		
	rector		Usual Residence of Decedent		·	1			,				
/land	MOI N		10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits		
Mary	is in	to	Maryland Montgom	erv	Silver S	Spring					1 ∐Yes 20K∑No		
the	r 28a-f show	irec	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?		
with	3a o	E D	1005 Rosemere Av	enue		20904	<b>.</b>		U.S	S.A.			
<b>-UUSO</b> hours after death with the Maryland	"natural", or items 23a or i	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or N	0- 14	1. Race - Americ Black, White,			
after	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No	1	il res, specily Cub 1 ∐ Yes 2⊠ No		o riicari, etc.)			lack		
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Z I 3-0030 thin 72 hours aft e.	natro fice	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occu kind of work done	pation during most of worked)	king	16b. Kind	d of Business/In	dustry		
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Naryiand d 2 should be file th and Mental Hv	d other than	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan			umame <sub>)</sub>			
Men Men	arke	은	Ayodele Newbury										
2 shc	is m aum		19a. Informant's Name/Relationship (	**	I		t and Number or Ru						
and and ealth	n 27 ner tr		Hastina Newbury/				Avenue,			ation - City or To			
es t	F te	1	20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ice)	Date		,			
altimore, mit. Pages 1 al	ant: ury	1 .9	4 □ Donation 5 □ Other (Specify								g, Maryland		
alt emit.	Important: If item 27 is marked other the any injury or other traumatic event, Inc. Once.		21. Signature of Funeral Service Licer	nshe /							Home, Inc.		
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death		
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تُ ق	an al rial-t	Щ	resulting in death) Last	Due to (or as a c	onsequence of):								
<b>58 / 5U,</b> ificate be executed	physician and the burial-transit	dical		d									
	as th		I F F F W I F			_		-					
death certif	attending p for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		☐ Ectopic pregnar	ncv		2	3d. Date of deliv			
	e att	icia	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at til		Other (specify)				Month	Day Year		
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<u> </u>	certificate ha irector, page		25. Was case referred to medical				26. Place of De			1 1 103	2 🗆 110		
OT VITA Physician:	s cert lirect	o Be	examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 🔀 Innation	2 ☐ ER/Outpatie	ent 3 DOA O	ther:			Other (Spec	cify)		
P F	er this eral dir	Ë	27. Manner of Death	28a. Date of Injury	28b. Time			28d. Describ					
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VISION Attending	ctor y the	fica	3 ☐ Suicide 6 ☐ Could not b	Zoe. Place of Injury	- At home, farm, st	treet, factory, office					ral Route Number,		
DIVISION OT VITAL I or Attending Physician: T after death.	To the Funeral Director: A completely filled in by the fi	Certification: To	4 Homicide	building, etc.	(эресіту)			Lity or I	own, State)				
spita	neral		29a. Certifier 1 X Certifying P	hysician: To the best of	my knowledge, dea	ath occurred at the	time, date and place	ce, and due to t	he cause(s)	and manner as	stated.		
e Hos	e Fur	Medical	(Check only 2 Medical Example)	miner: On the basis of e and manner state	xamination and/or i	investigation, in my	opinion, death occ	urred at the tim	e, date and	place, and due	to the cause(s)		
o th¢	omp	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date	e signed (Month	n, Day, Year)		
			Afre			D-6	4100		Jun	e 8, 20	109		
	12		30. Name and address of person who	completed cause of dea	th (Item 23a) (Tyne	, Print)							
			Smitha Bhikkaj	i, MD, 1500	Forest (	Glen Road	l, Silve S	Spring,	Mary]	Land 209	910		
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11, 2009 JEAN ELIZABETH WILKERSON OATES JUNE 10:26 A<sup>M</sup> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1951 Months Days Hours NOVEMBER 9. SOUTH CAROLINA 1 □ M 2 □ F 57 238-90-5856 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No OXON HILL MARYLAND PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 UNITED STATES 6033 LIVINGSTON ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 Ϊ No Specify. Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 YEARS BANKING LOAN OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY CATTIE WEBB WILKERSON BILLY WILKERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8665 PICKFORD STREET #6, LOS ANGLES, CALIFORNIA 90035 KRISTAL OATES / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State BRINSFIFID-ECHOLS CREMATORY JUNE 15, 2009 CHARLOTTE HALL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Tylure of Fun at Se, to ligand a LYDIA C. THORNION JOHNSON THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer Tastatic resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a, State

Director

Funeral

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Completed

Be

**Funeral** 

Director

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permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m. any injury or other traum: once.

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within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore.

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Examine

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Certification:

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IF FEMALE

and burialphysician the burial attending p the detached þ signed by the sign of the sign as 2 certificate

death certificate be executed

Box 68760

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Division of Vital Records,

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica itely filled in by the funeral director, p

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25. Was case refer	red to medical			26. Place of Dea	ath (Check only one)
examiner? 1 Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ 0	lome 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Dear 1 Natural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factorify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only					e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)

ı	one)	and man	iei sta
I	29b. Signature and title of	Certifier	
I	(1/	1	
I	17	111	-1

D46741

29d. Date signed (Month, Day, Year) June 11, 2009

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Dee pak Dachdeva,

MD

Livingston Koad, Fort Washington

State Registrar

n 24 hours af ie Funeral Di pletely filled in

the within To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:36 PM June Henry Melvin Powell 20 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 8,1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Country) MD Months 1 XM 2 F 220-12-5167 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County XXYes 2 No Hancock Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21750 IISA 246 Maryland Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

18. Mother's Name (First, Middle, Maiden Surname)

Grove Funeral Home, P.A. Hancock, MD 21750-0368

Harriet Alice Hepler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

246 Maryland Avenue Hancock, MD 21750

Aircraft Manufacture

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

06/20/00

Approximate Interval Between Onset and Death

06/24/2009 Warfordsburg, PA

141 West Main Street

Mechanical Draftsman

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mays Chapel

Physician /Medical Examiner

Hospital or Attending Physiclan: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

injury or Department Important: If any Injury o

**Physician** 

/Medical

**Examiner** 

10a. State

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Jacob Elmer Powell

4 ☐ Donation 5 ☐ Other (Specify)

Signature of Funeral Service Licensee

19a. Informant's Name/Relationship (Type. Print)

Verleen Liner/Daughter

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Director

Funeral

2

Completed

Be

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinant be notified at

72 hours after

. Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked ott

Baltimore, Maryland 21215-0036

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): とかしなか Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transi Chronc that initiated events resulting in death) Last (ORON ARY Physician/Medical signed by the attending I IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed ector. 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral dir Certification: To After this 28b. Time of 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death (Month, Day, Year) Injury 5 Pending investigation 1 Natural 1 □Yes 2 □No 24 hours after death. Pruneral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier within 24 hor To the Fune completely fi 29b. Signature and title of certifier 29c. License number MOHUMMED D66892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed Aziz, M.D.

31. Date filed (Month, Day, Year,

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2- No 2 No 1 TYes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

3

State Registrar 251 East Antietam Street Hagerstown, MD 21740

	-	State of Maryland / D	epartment of Health a Certificate of Death		tal Hygien Reg. N	Em 0 0 0	20754
		Registrar  1. Decedent's Name (First, Middle, Last)			ate of Death	av Year	3. Time of Death
Physicia /Medic		Robert W. Parsons			when the	2009	23:04
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	of Death	4	c. County of Death	
		Peninsula Regional Medical Cente	Salishur oday If Under 1 Year If Under	24 Hrs. ] 8, [	Note of Pirth	Wicom	lace (State or Foreign
Funeral		5. Social Security Number	Months Days Hours	Min. 2/	Date of Birth Month, Day, Yea 12/1926	r) Coun	NY
Director	-	Usual Residence of Decedent			12/1320		
/land		10a. State 10b. County 10c. City, Town	or Location			1	0d. Inside City Limits
Mar.	Ş	MD Wicomico Salisbu	ry				1 □Yes 2X No
th the	Director	10e. Street and Number	10f. Zip Code			Citizen of What Cour	itry?
ath wi	la	431 Parkwood Dr.	21804	deing (Coorie)		USA 14. Race - Americ	ean Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Eversions invest be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ XWidowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ XYes 2 □ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Orlif Yes, specify Cuban, Mexican  1 □Yes 2 ☒No Specify:		n, etc.)	Black, White,	
2 hour		15, Decedent's Education 16a.	Decedent's Usual Occupation	et of working	16b.	Kind of Business/Inc	dustry
hin 72 9.	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	St of Working			
d with	Con	12 M	lilitary			US Govern	nent
be file d oth event	Be	17. Father's Name (First, Middle, Last)	i i		rst, Middle, Maid	en Surname)	
ould ould arke	٩	Lee Parsons	Mailing Address (Street and Numb	a Cropp		v or Town State Zir	Code)
d 2 sh d 2 sh th and 7 is n traun			223 W. Tammy Dr.				
1 and 1 and		·	Disposition (Name of y, crematory or other place)	Date		Location - City or To	
ages ent of tr: If it			oury UM Cemetery	6/13.	2009 Re	liance, M	D
Deficiency permit. Pages Department of Important: If it any Injury or of		21. Signature of Funeral Service Licensee	22. Name and Address of Facilities 108 William St.	lity Burb	age Fun	eral Home	
		23a. Party. Enter the disease, or complications that caused the death. Do n					Approximate Interval Between
Physician	ž,	shock, or heart failure. List only one cause on each line.	ntracranial				Onset and Death
/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of the consequen		1000	0		6 70.5
Examiner		h	Asag				10years
р ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
ecute and trans	Examiner	Cause (Disease or injury that initiated events c	I+TN				3 4 Car
ate be ex hysician the burial	al E	5					
ficate phys the	edical	d					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Attential certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	very Day Year
that the ed by Jetach		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part	ti.	23e. Did tobac	co use contribute to	the cause of death?
law requires t as been signe 2 should be c	d by				1 ☐ Yes	2 No 3 □ Pro	bably 4 🗌 Unknown
w request	Completed				24a. Was an	24b. Were aut	opsy findings available
The la te has	E G	And the property of the second			autopsy performed 1 □ Yes 2 🔽	? death?	ompletion of cause of 2 No
VICAL Siclan: T certifical rector, pa	BeC	25. Was case referred to medical	26. Plac	ce of Death (C	heck only one)		
nysici		examiner? 1 Yes 2 No Hospital: 1 No Inpatient 2 ER/Ou	tpatient 3 DOA Other: 4 D	Nursing Home	5 Residenc	e 6 ∐Other (Spec	eify)
ng Pt C	Ë		Firme of 28c. Injury at njury Work?		. Describe how i	injury occurred	
rendin eath. or: A the fu	catio	2 Accident investigation	M   1□Yes 2□		Logotion (Circo	t and Number or Ru	ml Poute Number
I or Attending Phy after death.  Director: After this din by the funeral or	ertification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, ractory, office	201.	City or Town, S	State)	ar riodic rambor,
lospital hours a hours a uneral I	ledical Ce	29a. Certifier  (Check only (Check only a Medical Examiner: On the basis of examination and the manufacture)	e, death occurred at the time, date	and place, and leath occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
the L thin 24 the F mplete	Medi	one) and manner stated.  29b. Signature and title of certifier	29c. License number			. Date signed (Month	
<b>₽</b> ₹ <b>₽</b> 8	-	h	No. FI	2 50	J	une 10 h	ñ 2009.
•		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	39.7		sha Na	1
BA10+1		1415 S. DIVISION ST SALISE	OURY MD 218	04 1	DR. US	sha Na	resam
Sta Registr		31. Date filed (Month, Day, Year)  JUN 15 2009  32. Registrar's Signature	pars				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of De Decedent's Name (First, Middle, Last) **Physician** /Medical City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number Examiner **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Months Days Hours 1 M 2 X F GEORGIA MARCH 52 **Director** 105-50-9428 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits with the Maryland or 28a-f show notified at 10a. State 10h County 1 ☐xYes 2 ☐ No **Funeral Director** UPPER MARLBORO PRINCE GEORGE'S MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Numbe Ъ r items 23a or ner must be i USA 20772 12120 OLD COLONY DRIVE Pages 1 and 2 should be filed within 72 hours after death Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status Examiner 1 Never Married 2X Married 1 Yes If Yes, Give BLACK ò 1 ☐ Yes 2 X No Specify Specify: ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE 2 YRS SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F 27 is marked ot traumatic ever IDA ROBERTS DOLE GEORGE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12120 OLD COLONY DRIVE UPPER MARLBORO, MARYLAND 20772 ROBERT PHILLIPS /HUSBAND t of Health of : If item 27 or other t Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND Department c Important: If any injury or once. RIVERDALE CREMATORY 6/20/2009 Other (Specify) 4 Donation J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility anature of Fune 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cluss on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 \sum Nursing Home Hospital: 1 🗌 Yes 2 NO 1 Nnpatient 2 - ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 3 Suicide Could not be 28f Location, (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral D

Baltimore, Maryland 21215-0036

State Registrar

7

31. Date filed (Month, Day, Year) JUN 1 6 2009

determined

4 Homicide

(check only one)

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Bes.000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

(Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year of 11:38 **Physician** 13 **Evelyn** M. Price /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Somerset Manokin Manor Nursing Home Princess Anne Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Hours Days Min 1 □ M 2 🛣 F 216-20-7660 84 09-12-1924 Maryland Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evannice or out by motified at once. 1XYes 2 □ No Director MD Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11974 Edgehill Terrace 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify þ Pages 1 and 2 should be filed within 72 hours 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelvn Webster William Wheatley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28629 Deal Island Road, Princess Anne, MD Vanessa Lawrence/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Chance, Maryland 06-17-2009 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 22. Name and Address of Facility Hinman Funeral Home Signature of Fune al Service License Princess Anne, MD 21853 M00295 11673 Somerset Ave., 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner ev4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Physician/Medical the attending pl for use as t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s deatn? 1 ∐Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Man of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this certific al director, within 24 hours after death

To the Funeral Director:
completely filled in by the the

Medical 2 State

VEL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. DIVISION such 1415

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5 ☐ Pending investigation

6 □ Could not be

determined

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rosenberg /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** The Johns Hopkins Hospital Baltimore **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 207-30-5094 Aug. 24, 1940 68 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at PA YORK Director YORK 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 3 2205 Ashleigh Drive 17402 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 😿 Married 21215-0036 'natural", or 1 Yes XX No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 Widowed 4 Divorced Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Owner Consulting Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be Milton Rosenberg Dorothy Greenblatt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha F. Rosenberg Wife 2205 Ashleigh Dr. York, PA 17402 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Hill Hebrew June 22,2009 York, PA 17403 21. Signature of Funeral Service Licensee Geiple Funeral Home, Inc. #CC0265 #CC0265 53 Main St
Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 53 Main St. Glen Rock, PA 1732 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due ! (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 TYes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1. Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Director; After 1 Natural 5 Pending investigation Injury 1 Yes 2 No hours after death. 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wine 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	Otato of Marylana	Certificate of Death	Reg. N	2009 20758
	Physici		Decedent's Name (First, Middle, Last     Roger		izer	2. Date of Death Month D	3. Time of Death S:00P M
and a	/Medio Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death
- Andrew			18507 McMullen		Rawlings  hirthday) If Under 1 Year   If Under 24 Hrs.	O Date of Birth	Allegany
	Funeral Director		5. Social Security Number  215-42-4428  Usual Residence of Decedent	7. Age (In yrs. last	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year May 15,	9. Birthplace (State or Foreign Country) MD
	yland how		10a. State 10b. County		own or Location		10d. Inside City Limits
	the Mai 28a-f s	Director	MD Allega	any	Rawlings		1 □Yes 2 □No
	ath with the 23a or 2	ral Dir	10e. Street and Number 18507 McMullen	Hwy.	10f. Zip Code 21557		Citizen of What Country?  USA
9800	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it a Medical Examinar ment be reaffined at	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto</li> <li>1 □Yes 2 □ No Specify:</li> </ul>	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
15-0	"natural",	letec	15. Decedent's Edu (Specify only highest grad	cation 1 e completed)	<ol> <li>Decedent's Usual Occupation         (Give kind of work done during most of work life. DO NOT use retired)     </li> </ol>	16b.	Kind of Business/Industry
212	d within 72 giene. ir than "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	assistant manager	ŀ	nousekeeping
Maryland 21215-0036	2 should be filed of and Mental Hygin is marked other raumatic event, it	To Be (	17. Father's Name (First, Middle, Last) Walter S. Rize	r		e (First, Middle, Maide a Swauge	,
	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked othe or other traumatic event,		19a. Informant's Name/Relationship (7) Sandra Rizer	wife vpe. Print)	19b. Mailing Address (Street and Number or Ru 18507 McMullen Hwy	ral Route Number, City '. Rawlin	or Town, State, Zip Code) ngs MD 21557
Baltimore,	. Pages 1 and 2 tment of Health tant: If item 27 i jury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	e of Disposition (Name of etery, crematory or other place) lawn Memorial Gardens	Date 20c.	Location - City or Town, State  LaVale  MD
Balti	permit. Departn Importa any Inju	Ì	21. Signature of Funeral Service/Licens		22. Name and Address of Facility Scarpelli Funeral F 108 Virginia Avenu		MD 21502
			23a. Part . Enter t. e diseas -, or cr mpl	ications that sused the death. I	Do not enter the mode of dying, such as cardiac		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ends to	ellett fife U	en Conc	Onset and Death  One year
1	Examiner			Due to (or as a consequent	ce of):	1	
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):		
Mg.	ortificate be executed ing physician and s as the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):		
68760,	icate t physic s the b	Medical	•	d			
O. Box (		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deati 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
S, P	gned b	by Ph	Part II. Other significant conditions col	ntributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ord	require een sl	ted				1 🗆 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	The law cate has b page 2 sl	Completed				24a. Was an autopsy performed?	24b Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vita	slcian: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	
o	ding Phys	일	27. Manner Death	1   Inpatient 2   EH/	b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how inj	6 ☐Other (Specify)
ion	Attending death. ctor: Afte y the fun	atio	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day, Year)	Injury Work? M 1 □Yes 2 □No		
É	tal or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated.  Indicate the cause (s)
	Vith Com	Σ	29b. Signature and title of certifier	1/20 - 11.	29c. License number	29d. [	Date signed (Month, Day, Year)
	,	-	30. Name and address of person who co	ompleted cause of death (Item 23	(Type, Print)	fi	yne dd 2007
	6		GARY WAGON	\$, m. D. 9	25 BISHOP WALSH	DR. Kur	MBIERLAND, MID
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:00 P M 9 2009 June DAVID WAYNE ROSS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Kline Hospice House Mount Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 019-38-6647 54 Sept. 6,1954 Director Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shoot the Wedical Examinations be notified at 1 ☐Yes 2 ☐ No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1413 Hunting Horn Lane United permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, Its Modical Examplement once. 21703 States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst Consulting Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wayne Ross Simonetti ပ္ Sylvia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Μ. 1413 Hunting Horn Lane / Frederick, MD. Kim Ross / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/11/2009 | Frederick, Maryland Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Expert the disease, or complications that caused the death. Do not enter the mode of dyin, shock, sheart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death)

a. Complete (Section 2014) 1621 Opossumtown Pike/ Frederick, MD 21702 Approximate Interval Between **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) House Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manper of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the fi 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records,

P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours a

To the Funeral [ 12

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy

ESKANder, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Mar			t of He	ealth a		ental Hyg	liene eg. No.	9	20760
	Physici /Medic	20.00	1. Decedent's Name (First, Middle, Las Esther Elenor Re	•						2. Date of Dea Month 06/12/2	Day `	Year	3. Time of Death  10:50P
S. S. S. S. S. S. S. S. S. S. S. S. S. S	Examir		4a. Facility Name (If not institution, give Maplewood Park P.	lace		Beth	esda	Location of		O. Data of Birth	4c. County of	omery	
**************************************	Funeral Director		5. Social Security Number 467 12 9958 11  Usual Residence of Decedent		(In yrs. last birtho	Months		Hours	Min.	8. Date of Birth (Month, Day 03/04/	Year) 1907		ace (State or Foreign ry) 1inois
	e-f show	ctor	10a. State 10b. County MD Montgor		10c. City, Town o	Bethes	da					10	od. Inside City Limits 1X Yes 2 □ No
99	72 hours after death with the Maryland instural, or Items 23a or 28a-f show dissal Examirrar must be notified at	/ Funeral Director	10e. Street and Number  9707 01d Georgeto  11. Marital Status  1 □ Never Married 2 □ Married	wn Road #3a  12. Was Decedent Ev Armed Forces?  1 fg Yes 2 \subseteq No II Yes, Give	ver in U.S.	10f. Zip 2 13. Was Deced If Yes, spec	20814 lent of His		in? (Spe Puerto F			Stat	tes an Indian, otc.
Maryland 21215-0036	within ane. than	Completed by	3 △ Widowed 4 □ Divorced  15. Decedent's Ed (Specify only highest grade)  Elementary/Secondary (0-12)  2	Year or Dates:	1939 16a. D	ecedent's Usua Give kind of wor ife. DO NOT us	I Occupa	tion uring most	of workir	ng	16b. Kind of Bus	iness/Indu	
<b>Aaryland</b>	2 should be and Mental Is marked o	To Be C	17. Father's Name (First, Middle, Last)  John Adams Pric  19a. Informant's Name/Relationship (7  Jana Scott/Niece		19b. N	Mailing Address  5 Corde	(Street a	Es:	sie (	Gertrud Route Numbe	e Brokaw r, City or Town, S	7	
Baltimore, I	Pages 1 an ment of Heal ant: If item 2 ury or other		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of D cometery, Arlingt	Disposition (Name or or or or or or or or or or or or or	ne of ther place onal	Cem.	7/24	109	20c. Location - C	on, V	wn, State
Balt	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Liver	Mury		5130 V	Visco	nsin	Ave	,NW W	wler's S ashingto	n, D	
760,	Physician /Medical Examiner and prize priz	Jicai Examiner	23a. Part1. Enter the disease for forms shock, or heart failure. List only of the shock of heart failure. List only of the shock of the	a. Fau Due to (or as a Due to (or as a c.	consequence of)	To			riv				Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic pro					23d. Date Mont		ry Day Year
Vital Records, P.	w requires that been signed to should be deta	Completed by PI	Part II. Other significant conditions of	Fibelli	not resulting in the	he undertying ca	Se(	n in Part I. ASC	-	23e. Did to 1 ☐ Y	es 2000	3 🗌 Proba	e cause of death?  ably 4 Unknown  osy findings available
ital Re		Be Comp	HyperHent  25. Was case referred to medical examiner?	UM	21 [0]		in page 17 and	26. Place	of Death	autop	sy pr med? de 2 No 1	rior to comeath?	npletion of cause of
Division of V	anding Physiath. or: After this he funeral di	၉	1 Yes 2 No  27 Manner of Death  Natural 5 Pending 2 Accident investigation	Hospital: 1  Inpatien 28a. Date of Injury (Month, Day	28b. Tin		8c. Injury Work	4 Nur	2		ence 6 Other		')
Divis	p di ji ∈	Certification:	3 Suicide 6 Could not be determined	building, etc.	(Specify)					City or Tow			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1	vsician: To the best of iner: On the basis of and manner state	examination and/	or investigation,	at the tim , in my op License	inion, deat	d place, a h occurre	ed at the time, o	cause(s) and man date and place, and 29d. Date signed	nd due to	the cause(s)
	/O		> Merly	vompleted cause of do	muy	nus	D	35	79,	/	6/13	100	9
4			30. Name and address of person who of MERLYN ENG.  31. Date filed (Month, Day, Year)  JUN 15	LRY, HO	's Signature	1 GE	ORG	-1A	A	VE,	WITE	2.	27
	Sta Regist		JUN 15	2009 Eleve	un A.	park	1	DIL	VII	- OF	74100		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7:25 P M June 5. 2009 Curtis Royster, III /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital of Birth (h, Day, Year)

28, 1985 of Columbia 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1**X** M 2□ F Director 23 Nov. 220-21-3562 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County show 1 ☐ Yes 2 X No ns 23a or 28a-f st must be notified Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5601 Lake Christopher Drive 20855 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Evaminer moonee. 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Curtis Royster, Jr. Helena Little 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Lake Christopher Drive, Rockville, MD 20855 Curtis Royster, Jr. / Father Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/13/2009 | Olney, Maryland Norbeck Mem. Park 21. Signature of Funeral - rvice Lin 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 Days a Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 Days b Occluded Tracheostomy Sequentially list conditions, Examiner d'any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed 2 Days Mucus Plug and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Advanced Cerebral Palsy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 □ No 1 □Yes 1 ☐Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2XINo 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 🛣 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Injury To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DJU58542 : Claus - Town tonic JUNE 10, 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LIBUSE HEINZ-MOMCICSVIC, 13605 CONCORD STREET # 500, KERSINGTOR, MID

20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 15 Registrar knews

DHMH 17 Rev 1/2001

			State of Maryland / De State of Maryland / De	epartment of He Certificate of De			ene 200	9 20762
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		EVANGELINE 140			06	11 2009	2034 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death	-	4c. County of Dea	ath
w.			Montgomery General Hospital	Olney			Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)   C	rthplace (State or Foreign ountry)
	Director		213-58-8779 1 1 M 2M F 65 Yr Usual Residence of Decedent	s.		Nov 10,	1943   In	dia
	and ow		10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits
	Mary f sh	р	Maryland Montgomery Silver	Spring				1 □Yes 2X No
	the 28a notif	Director	Maryland Montgomery Silver  10e. Street and Number	10f. Zip Code		100	g. Citizen of What C	ountry?
	3a or	<u>~</u>	16920 Harbour Town Dr	20905		11	ISA	
	ms 2	Funeral		13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe		14. Race - Am	
9	within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give	37	Mexican, Puerto i Specify:	Alcan, etc.)	Black, Whi	te, etc.
93	ral",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	To tes ZEANO S	Specify.		Specify: Asi	an Indian
2	72 ho	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (0	ecedent's Usual Occupation  Give kind of work done during  ife. DO NOT use retired)	on ing most of workir	ng   16	6b. Kind of Business	s/Industry
1215-0036	filed within Hygiene. other than "	dm	Elementary/Secondary (0-12) College (1-4or 5+)		•			_
2	e filed wal Hygie other t			ministrator	O. Matharia Nama	(First, Middle, Ma	World Ban	ık
änc	s T of g	Be	17. Father's Name (First, Middle, Last)				alueri Surriarrie)	
$\frac{8}{5}$	should be filed and Mental Hygi s marked other umatic event, 1	P	G.A. Anandam	Mailing Address (Street and	Julia Va		City - Town Chate	Zin Codo)
a N	12 st th and 7 is r traur		, ,	•				
o,	es 1 and 2 should b of Health and Ment item 27 is markec r other traumatic e			20 Harbour To			oc. Location - City of	
چ	Pages 1 ar ment of Hes ant: If item ury or othe		LABURAL 2 LI Cremation 3 Li Removal Ironi State	isposition (Name of crematory or other place)			·	
Baltimore, Maryland 2	ift. Partime	8	4 □ Donation 5 □ Other (Specify) / George	Washington				., MD 1 Home, Inc.
B	permit. Page Department of Important: If any injury or once.		21. Signatur on the state in th					ng, MD 20904
		_	23a. Part1. Enter the disease, or complications that caused the death. Do no					Approximate
	Dhysisian		shock, or leart failure. List only one cause on each line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due o (or as a consequence of)	zy EmBo	0102			MINSTES
-	Examiner		Data to (of ab a solitorique) of)	·W .				
		Jer	Sequentially list conditions, if any Use immediate Due to or as a consequence of	,	22			
	cutec nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
Ď,	e exe ian al ırial-t		resulting in death) Last Due to (or as a consequence of)					
98760	death certificate be executed e attending physician and d for use as the burial-transit	edical	d					
_	ertific ding p		IF FEMALE:					
Ř	leath certifi attending I for use as	ician/M	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy			23d. Date of de Month	elivery Day Year
o.	the a	ysic	1 ☐ Yes 2 Dolo 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)				
J.	that ted by	Physi	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given	in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Vital Records,	law requires that the di as been signed by the 2 should be detached	d by	Sepsis			1 □ Yes	6 2 No 3 I	Probably 4 Unknown
င္ပ	w req	Completed	CARDIOMYOPATHY RENAL FAILURE			24a, Was an	24b. Were a	autopsy findings available
Å T	The lar ate has bage 2	щ	Round Entire			autopsy perform	prior to	completion of cause of
g	ifficat or, pa	e C	25. Was case referred to medical	0	IC Blood of Dooth	1 □ Yes 2 (Check only one)		es 2 No
5	/sicial	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp				nce 6 □Other (Sp	necifu)
0	ding Physician: The law h. After this certificate has funeral director, page 2 s	ä	27. Manner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury a		28d. Describe hov		oony)
0	ndin ath. r; Aft	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Inju 2 ☐ Accident investigation		s 2□No			
Division	er der er der recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	2	28f. Location (Stre City or Town,		Rural Route Number,
5	tal or rs after all or rs after all Dil	Cer						
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only   Medical Examiner: On the basis of examination and/	or investigation in my only	sion doath coour	and at the time da	to and place, and di	in to the causeo(c)
	the I	Medi	one) and manner stated.	200 11000	number		Id Date signed (Max	oth Day Year)
	우 첫 <b>오</b> 등	-	29b. Signature and title of contific	29c. License n	rumber	29	a. Date signed (Mo)	7 00 G
	5		Kall the Mo	D001-	3867	-	00 / 4	
-			30. Name and address of person who completed cause of death (Item 23a) (Ty	ype, Print)	a Ri.	0 6.1	- 110m	mo zagen
	Sta	e.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- CONTORAL	C 134V	D 3011	2 100	1110 60050
	Registr		29b. Signature and title of certification and manner stated.  30. Name and address of person who completed cause of death (Item 23a) (Type 13a). Date filled (Month, Day, Year)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	backet				

Box 68760.

of Vital

**Division** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** LORETTA M. STEELE 1603 M 2/10 9 Tune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SB11361111 Viconia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 😾 F Hours DELAWARE 85 221-20-5416 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f sho event, it e Medical Examinar must be notified at DAGSBORO Director DELAWARE SUSSEX 1 □Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19939 US 32150 DUPONT BLVD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 Never Married 2 Married 0 Maryland 21215-0036 WHITE 1 ☐ Yes 2X No If Yes, Give Year or Dates: Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental h Be Pages 1 and 2 should be FLOSSIE FISHER RAYMOND H. BRUMBLEY other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JAMES R. STEELE/ SON 32150 DUPONT BLVD, DAGSBORO, DE. 19939 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date jo = 5 1 X Burjal 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or DAGSBORO REDMENS 6-15-09 DAGSBORO, DELAWARE 4 Donation 21. Signature of eral <del>S</del> MELSON FUNERAL SERVICES, LTD 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, aftending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death Director: 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

BA 10

State Registrar

JUN 15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St.

29b. Signature and title of certifie

Douglas Wilhite

31. Date filed (Month, Day, Year)



29c. License number

29d. Date signed (Month, Day, Year)

1 - For State Registrar	State of Maryland		rtment of H		nd Menta	al Hygiei	2000	20765			
1. Decedent's Name (First, Midd						ate of Death	Day Yeer	3. Time of Death			
Physician Mary Goode S					Ju	_	2009	12:25p M			
Examiner 4a. Fecility Name (If not institution			4b. City, Town, or	Location of	Death		4c. County of Death Prince George's				
Greater Laure L  5. Social Security Number	Health and Rehab.  6. Sex 7. Age (In yrs. last	t birthday)	Laurel	if Under 24	4 Hrs. 8. Da	ate of Birth	9. Birti	nplace (State or Foreign			
Director 227-46-7778	1□M 250 F 96	Yrs.	Months Days	Hours	Min. 8/2	onth, Day, Ye 23/1912	Vir	ginia			
Usuel Residence of Decedent  10a. State 10b. Coun	ty 10c, City, 1	Town or Loca	ation					10d. Inside City Limits			
Maryland Princ	e George's Laure	e1						1 ZYes 2 ☐ No			
9 10e. Street and Number			10f. Zip Code			10g.	Citizen of What Co	untry?			
ទ្ធ និង 👼 14200 Laurel P	ark Drive		20707				JSA				
To. State    10a. State   10b. Counter   10c. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   10e. Street and Number   14200 Laure1   Princ   16200 Laure1   Princ	If Yes, Give		as Decedent of Hi Yes, specify Cubar	spanic Origi n, Mexican, Specify:	in? (Specify Y Puerto Rican,	es or No- , etc.)	14. Race - Ame Black, White Specify:				
3 Midowed 4 Divorce  15. Decede  (Specify only high  Elementary/Secondary (0-12)  12		16a. Decede	ent's Usual Occupa	ation	of working	16b	o. Kind of Business/	Industry			
T5. Deceded (Specify only high Elementary/Secondary (0-12) 12 Deceded (Specify only high Elementary) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (Specify only high Elementary (0-12) 12 Deceded (0-12) 12 Deceded (0-12) 12 Deceded (0-12) 12 Deceded (0-12) 12 Deceded (0-12) 12 Deceded (0-12) 12 Deceded (0	College (1-4or 5+)		ind of work done o O NOT use retired,	)	or working		Private				
ス 多	e (ast)	Hous	ekeeper	18. Mother	's Name (First	t, Middle, Mai	den Surname)				
o Frank Goode	, 240,				lice Sm		·				
		19b. Mailing	Address (Street a	and Number	or Rural Rou	te Number, C	ity or Town, State, 2	Zip Code) 30058			
Wilhelmina Wil			Deshon C	reek (	Date	- V	. Location - City or				
20a. Method of Disposition  1	n 3 □Removal from State	netery, cremi	ition (Name of atory or other place	,							
Bunar 2 Cremation  1			1n Cemet Name and Addres		/12/200 Fort	Jy Br Lincol	entwood, n Funera				
Ba and modern and mode	5/man		01 Blade					20722			
Immediate Cause (Final disease or condition	or the tions had caused the death. st may one cause on each line.	Do not ente	r the mode of dying	g, such as c	e ardiac or resp	oiratory arrest,		Approximate Interval Between Onset and Death			
/Medical resulting in death) Examiner	Due to (or as a consequer	nce of):						- N			
Sequentially list conditions, if any, leading to immediate	b. Oue to (or as a consequen	nce uf).			_						
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b> .										
	Due to (or as a consequen	nce of):									
876(876)	d			_							
that the death certifical points of the death certifical point	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetel ok 4 Pregnant at time of deal	eath 3⊟6	Ectopic pregnancy Other (specify)		20.000		23d. Date of del Month	ivery Day Year			
A Part II. Other significant condi	tions contributing to death but not resulti	ing in the un	derlying cause give	en in Part I.	2	23e. Did tobac	co use contribute to	the cause of death?			
w require w require should be signed to should be signed to should be should	nonary A	Men	4 0	esea	M	1 🗆 Yes	2 (Sats) 3 □ Pi	obably 4 Unknown			
The la the has sage 2 comp						4a. Was an autopsy performed Yes 2	prior to	utopsy findings available completion of cause of			
25. Was case referred to medic examiner?	Hospital:	210	Othe	200	of Death (Che	-	- C DOther (Con				
1 ☐ Yes 2 TNo 27. Manner of D ath	28a. Date of Injury 28	R/Outpatient 8b. Time of	28c. Injury Work	-	-		e 6 □Other (Spe injury occurred	cny)			
The particular of particular o	stigation	Injury		Yes 2 □ N	lo						
Cert Cert	d not be mined 28e. Place of tnjury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office			ocation (Stree City or Town, S	at and Number or R State)	ural Route Number,			
the Hospital County one)  Solution 124 hours in 24 hours one)  Solution 125 Certifier one)  Solution 2 hospital one in 24 hours one)	ring Physicien: To the best of my knowle al Examiner: On the basis of examination and manner stated.	edge, death in and/or inv	estigation, in my or	pinion, death	d place, and d h occurred at	the time, date	and place, and due	o to the cause(s)			
within 2 complete the country one)  29b. Signature and title of certification one)	The state of the s	M.8	29c. License	24	721	290	Date signed (Moni	Z 2009			
SYEN SA	on who completed cause of death (Item 2)  14 3 3 3  32. Registrar's Signatur	> 1	Aukre	- fw	WIR	B	LAURE	M) 20708			
State Registrar	32. Registrar's Signatur	park	/								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Of Maryland / Department of Health and No Registrar Certificate of Death		eg. No. 2	09 20766			
ı	Physici		1. Decedent's Name (First, Middle, Last) Raymond Alexander Schwartz	2. Date of Deat Month June 11	h ., <sup>Day</sup> 2009	3. Time of Death 7:23 p M			
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Holy Cross Hospital  4b. City, Town, or Location of Death Silver Spring		4c. County of				
4.	Funeral Director		5. Social Security Number 163-18-1340  6. Sex 1 M 2 F  7. Age (In yrs, last birthday) 89 Yrs.  1 Months Days Hours Min.	8. Date of Birth (Month, Day, July 30	Year) 1919	9. Birthplace (State or Foreign Country) Pennsylvania			
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	e Mary <b>3a-f sh</b>	ctor	Maryland Montgomery Silver Spring		1 ☐ Yes 2 🖪 No				
	th with th	Funeral Director	10e. Street and Number 3518 Everton Street 20906		USA	at Country?			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any hurry or other traumatic event, the Medical Examinating the inclined at once.	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White			
15-0	"natur	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Bus	iness/Industry			
212	d withir giene. rr than	omo	Elementary/Secondary (0-12) College (1-4or 5+) Photography			Government			
and	d be filed antal Hy ced othe c event,	Be	17. Father's Name (First, Middle, Last) Michael Schwartz  18. Mother's Name Mary	e (First, Middle, I Bartkows	Maiden Surname SKI	)			
Maryland 21215-0036	nd 2 should alth and Me 27 is mark r traumati	7	19a. Informant's Name/Relationship (Type. Print)  Jannie C. Schwartz/Wife  19b. Mailling Address (Street and Number or Run 3518 Everton Street	ral Route Number	r, City or Town, S r Spring	tate, Zip Code) , MD 20906			
Baltimore,	Pages 1 all ment of Heatant; If item jury or othe			June 15 2009		City or Town, State  Spring, Marylane			
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee  Francis J. Name and Address of Factions 500 University Blvd						
	Physician and Medical Examiner as the bural-transit	al Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Each Uncertainty Cause (Disease or injury that initiated events resulting in death) Last  Terminal Dementia  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			Interval Between Onset and Death			
O. Box	at the death certificate by the attending phy tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date Mon	e of delivery th Day Year			
rds, P.	es tha	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			bute to the cause of death?  3 ☐ Probably 4 ☐ Unknown			
Vital Records,	The law ate has t page 2 sl	e Completed	25. Was case referred to medical 26. Place of Dea	24a. Was a autopoperfor 1 □Yes	med? d 2 X No 1	/ere autopsy findings available rior to completion of cause of eath? □Yes 2□No			
o	ing Phys After this uneral dir	ation: To Be	examiner? Hospital: Other:	ome 5 ☐ Resid					
Division	al or Attend safter death   Director: .	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Numbern, State)	er or Rutal Route Number,			
	To the Hospital or within 24 hours after To the Funeral Directory completely filled in b	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	e, and due to the cred at the time,	cause(s) and ma date and place, a	nner as stated. nd due to the cause(s)			
h	15+1	Me	29b. Signature and title of certifier D68150	:	29d. Date signed Ju	(Month, Day, Year) ne 12, 2009			
	1011		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nejib Siraj, MD 1500 Forest Glen Road, Silver Spring	, MD 209	910				
	Sta Registi		31. Date filed (Month Bay, Year) 32. Registrar's Signature 6.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Carol Ann Foard Teate 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ARFORE 5. Social Security Number GRACE Year Homis 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🛛 F 65 215-40-0064 Yrs October 11,1943 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County Maryland Harford ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Aberdeen 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 247 Golf Drive 21001 Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy Injury or other traumatic event, the Megone. College (1-4or 5+) Human Resources Clerical 17. Father's Name (First, Middle, Last)
Thomas R. Found 18. Mother's Name (First, Middle, Maiden Surname) Be Cleo Cloak မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Elmore (Nephew) 247 Golf Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RA Ferris&Co., Inc. 06-23-2009 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) P.A. 210 Maryland 21. Signature of Fundal Salary Lionise 22. Name and Address of Facility Zellman Funeral Home, 123 S. Washington St. Havre de Grace, Approximate Interval Between Onset and Death 23a. Part1. Enter the eleease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Atter ding Physician; The law requires that the death certificate be executed 24 hours effer death. physician and the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 2 3 No 1∐ Yes Division or Vital 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral dir 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deal To the Funeral Uirector 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

			1 = For Stete Registrar	State of Maryland		irtment of H tificate of I		nd Mental Hy	ygiene Reg. No.	6007	20768
ì	Physicis	an.	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	/ Year	3. Time of Death
	Physicia /Medic		John Sherman Ta					June	12	2009	11:47 AM
4	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		f Death	4c.	County of Deat	n
	Formered		Calvert Manor Hea  5. Social Security Number 6. Sex			Rising S If Under 1 Year	Sun If Under 2	24 Hrs. 8. Date of B	irth	Cecil 9. Birt	hplace (State or Foreign untry)
	Funeral Director			M 2□F 94	Yrs.	Months Days	Hours	Min. (Month, E		1	untry) ginia
	p .		Usual Residence of Decedent	10c. City, 1	Town or Lo	antion			,		10d, Inside City Limits
	shov	٦	10a. State 10b. County	Toc. City,	IOWII OF LO	cation					1 ☐ Yes 2 🙀 No
	28e-f	Director	Maryland Cecil  10e. Street and Number	Nor	th Ea	ST 10f. Zip Code			10g. Cit	izen of What Co	untry?
	3a or	D	146 Razor Strap R	oad		2190	<b>1</b> 1			ted Sta	
	death ms 2	nera		12. Was Decedent Ever in U.S. Armed Forces?	13. \			gin? (Specify Yes or N , Puerto Rican, etc.)		14. Race - Ame Black, White	ncan Indian,
2	after or Ite	by Funeral	1 Never Married 2 Married	1 Dives 2 No If Yes, Give 1942-4.		Tes, specify Cubb	Specify:	, radito radan, did. y		1000	ite
3	hours ural',		3 Widowed 4 □ Divorced			lent's Usual Occup			16h K	ind of Business/	-
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7	with jene. r ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Μe	chanic				Electi	conics
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0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other traumetic event, the Medical Examinating the routilied at		19a. Informant's Name/Relationship (Ty					r or Rural Route Num			
ב บ	1 and Health Sm 27 ther t		Nancy Sue Falkenst 20a. Method of Disposition			Razor Sti	cap Ro	oad, North		, Maryl cation - City or	
2	Pages nent of H ant: If ite ury or of		1 XBurial 2 ☐ Cremation 3 ☐ P	lemoval from State cem	netery, crer	natory or other place	(e)	Tune 16,		deen, M	
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	/Medical		resulting in death)	Due to (or as a consequen		<u> </u>	61 614	4 7			^
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Š	th cer tendir r use	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy	,			23d. Date of de Month	ivery Day Year
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Ċ	hat th ad by Jetacl	Phy	Part II. Dther significant conditions cor	ntributing to death but not resulti	ing in the u	nderlying cause giv	en in Part I.	23e, Dio	tobacco	use contribute to	the cause of death?
ה	signe d be	d by		Courdising opin		,3		1 🗆	Yes 2	Mo 3 □ Pi	obably 4 Unknown
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	he lav e has age 2 :	Completed							topsy formed?	death?	completion of cause of
חממטו	L E G	O	25. Was case referred to medical				26. Place	of Death (Check only	~~	7 7 7 7 8 8	20140
ב	en: rtific stor,	~		to the f		Oth					
VII al ne	nysicien: nis certific i director,	o B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	3/Outpatier	t 3 DOA	er. 🍇 Nu	rsing Home 5 🗆 Re	sidence	6 ∐Other (Spe	cify)
טו אוומו חפי	ng Physicien: The law requires that the death certifica (ter this certificate has been signed by the attending phynneral director, page 2 should be detached for use as the	To B	1 Yes 2 No	1   Inpatient 2   Er	NOutpatier  8b. Time of Injury	28c. Injur	y at k?	28d. Describ			cify)
VII al ne	tending Physicien: The lar leath. tor: After this certificate has the funeral director, page 2	To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injur Wor	4 <b>X</b> JINU	28d. Describ	e how inju	ry occurred	
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טו אוומו חפי	spital or Attending Physicien: lours after death. neral Director: After this certific filled in by the funeral director,	Certification; To B	27. Manner of Death  1 Datural 2 Accident 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hom building, etc. (Specify)	8b. Time of Injury	28c. Injur Wor M 1 =	y at k? Yes 2 1	28d. Describ No 28f. Location City or T	e how inju (Street al own, State	ry occurred nd Number or R a)	ural Route Number,
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טו אוומו חפי	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical Certification; To B	27. Manner of Death  1 Datural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who co	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hombuilding, etc. (Specify)  sician: To the best of my knowled and manner stated.	8b. Time of Injury  e, farm, str  edge, death  n and/or in	28c. Injur Wor 1 = 28c, Injur Wor 1 = 28c, factory, office	y at k? Yes 2 I	28d. Describ No 28f. Location City or 7  d place, and due to the thoccurred at the time	(Street ar own, State	nd Number or R  a) and manner a: d place, and due  ate signed (Monite)	ural Route Number, s stated. e to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:45 A M DUNG HUU TRAN June 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1006 Parrs Ridge Drive Montgomery Spencerville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1⊠M 2□F 53 158-72-5061 January 1,1956 Vietnam Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Spencerville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1006 Parrs Ridge Drive 20868 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Asian Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Supermarket 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Η. Tran Xuan Thi Trinh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chi Thi Kim Troung/Spouse 1006 Parrs Ridge Drive, Spencerville, MD 20868 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park 06/15/2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring,MD 20904 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of jach line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition Glioblastoma Multiforme disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy perform 2 X No 1 ☐ Yes

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show

Director

Funeral

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Completed

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2 should be filed within 72 hours after or and Mental Hygiene. is marked other than "natural", or itel

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

attending physician for use as the buria signed by the a d be detached f has certificate

After

of Vital Records, P.O. Box 68760,

Division

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completely filled in by the funeral director, Certification: To Hospital or Attending P 24 hours after death. Funeral Director: After t

Physician/Medical ģ Completed Be

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To the Hospital within 24 hours a To the Funeral D 10 25. Was case referred to medical examiner? Hospital: 1 ∐ Yes 2 X No 27. Manner of Death 1 🛛 Natural 5 Pending investigation 2 Accident 3 🗌 Suicide 6 Could not be 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

and manner stated MP

28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

29c. License number D54486

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

12,2009

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ton Huyanh, MD, 7505 New Hampshire Avenue, Suite #310, Takoma Park, MD 20912 JUN 15 31. Date filed (Month, 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:35 A M 2009 David Taylor, Jr. 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 3772 Gardendale Drive Eden 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1X M 2□ F Director 6-19-1943 212**-**40-9200 65 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Wicomico Eden 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3772 Gardendale Drive Funeral 21822 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 196 If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1962-1965 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cemetery s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th Family Service Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be ဂ္ David С. Taylor, Sr. Helen Frazier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other trong. 3772 Gardendale Drive, Eden, Maryland 21822 Pat Taylor - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 6-12-2009 | Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only pre-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastic disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to ininiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of). Physician: The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 21 No Division of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 24 hours after death.

Funeral Director: After thi etely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of To the Hos within 24 hc o the Fune 29a. Certifier (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. completed cause of death (Item 23a) (Type, Print) 30. Name an 30434 MT. VERNON Rd. PRINCEN ANNE ANN egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:40 AM Walker **Physician** 200 MAR RaipH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth
March Day Year 1954 Virginia 5. Social Security Number If Under 1 Year If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Days Hours 55 227-78-6160 Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10h Count show at 1 Yes 2 No Fairfax Alexandria VA Director notified 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö must be r 22309 USA 9306 Old Mansion Drive 23a Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 11. Marital Status Examiner 1 Never Married 2 X Married 1 Yes If Yes, Give Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ō þ 3 Widowed 4 Divorced Year or Dates 'natural". Completed 16b. Kind of Business/Industry ntal Hygiene. ed other than "natura event, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) International College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Director of Facilities & Mgt. | Monetary Fund 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Fisher is marked of Helena Thiessen Douglas H Walker မ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Walker, Spouse 9306 Old Mansion Drive Alexandria VA 22309 Health a Department of Health Important: If Item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Everly Crematory 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 XCremation 3 Removal from State 06/20/2009 Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1500 W. Braddock Rd Everly-Wheatley FH mo1453 Alexandria VA 22302 Approximate Interval Between Onset and Death Gent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cla Apres disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hyperamonem. duc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Myeloma 4 ears the Hospital or Attending Physician: The law requires that the death certificate be executed physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specity) 2 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other:  $_{4} \square$  Nursing Home  $_{5} \square$  Residence  $_{6} \square$  Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 - Natural Injury 1 Tes 2 Accident Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 4 ☐ Homicide

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within 24 hours a To the Funeral D

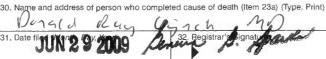
State

29a. Certifier

(check only one)

29b. Signature and title of certifier

Medical



and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2009

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-OUO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per phys. G893, 7/27/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 0645 AM EUGE.NE 2009 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hosptial Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months 1 X M 2 □ F Yrs. 82 April 1927 West Virginia Director 232-38-1154 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12105 Panthers Ridge Drive 20876 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 C&P Telephone Company Cable Splicing Foreman 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ပ William Bryan Wood Clovie Macil Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 19a. Informant's Name/Relationship (Type. Print) 12105 Panthers Ridge Drive, Germantown, Maryland ce of Disposition (Name of Date 20c. Location - City or Town, State Jane Nicholson, daughter item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If its any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodmere Memorial Park 6/18/2009 Huntington, West Virgin a 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23 Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hart failure. List only one cause on act line.

Imme the Cruse (Final disease or condition as a Cruse of the Cruse Approximate Interval Between Onset and Death **Physician** day /Medical Due to (or as a consequence of) Examiner Flash Pulmonary Edema l day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed Advanced Systemic Lupus Erythematosus Years Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065505 M.D 13,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHENG M.D QIUFANG 9901 ROCKVILLE. MD 20850 MEDICAL CENTER DR. 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 15 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician June 9. James 2009 Wantz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 9326 Wavnesboro Pike Emmitsburg If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, Oct 10, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 77 1931 217-26-7424 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Frederick Emmitsburg Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21727 9326 Waynesboro Pike Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1**★**Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) construction utility pipe layer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Elizabeth Eyler John Harry Wantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9326 Waynesboro Pike, Emmitsburg, Maryland Mary Jean Houck - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State Mountain View Cemetery 6-12-2009 Emmitsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses Stauffer Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 104 E. Main Street, Thurmont, Maryland Immediate Cause (Final ardio-kest watery **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of) attending physician Physician/Medical as the b IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 √res 2 No 3 Probably 4 Unknown

Division or Vital Records, P.O. Box 68760 Fredoven Attending Physician:

à Completed Be မ Certification:

cate has been signed by the page 2 should be detached certificate has funeral director, After this

Hospital or Attendii thours after death. Tuneral Director: A completely filled in by the within 24 hours at To the Funeral D Hospital LB

> State Registrar

Medical

1 ☐ !npatient

28a. Date of Injury (Month, Day Year)

and manner stated.

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

Month

24a, Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yes 2 No

28d. Describe how injury occurred

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

3. Time of Death

9:30 A.

9. Birthplace (State or Foreign

10d. Inside City Limits

white

21727

21788 Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad

31. Date filed (Month, Day, Year) JUN 11 2009

5 ☐ Pending investigation

6 Could not be determined

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Berta Weiss June 2009 8:55A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) October 21, 1922 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country 1 □ M 2 🖫 F 220-51-1759 86 Director Romania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Microst East, from cust. 1111 University Blvd West #618 Israel Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ Specify: Caucasian 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Doctor 5+ Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sami Hirschfeld Eva Marcus ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrian Weisz - Son 2 Autumn Ridge Court, Siver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 06/12/2009 Adelphi, Maryland 9 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tuperar Service Licenson 22. Name and Address of FacilityHines Rinaldi Funeral Home, Inc. Ne 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erebrovasca disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner <sup>9</sup> Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
<sup>9</sup> Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ vanced After this certificate has been so funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Division of Vital 1 □Yes 1 ☐ Yes 2 ☐ No 2 400 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2

State Registrar 29b. Signature and title

30. Name and address of person who cor

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71

3 32. Registrar's Signature

kewij

5

29c. License number

D31001

Noteted cause of death (Item 23a) (Type, Print) 7500 Green way Catr. Dr. #430

Greenbelt, MD

29d. Date signed (Month, Day, Year)

6/11/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per FH G893.7/17/09 JH/ Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** 2009 10, 1446 JUNE VERNON A. WILLIAMS /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S 5. Social Security Number 4126 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F Months Days Hours Min Director 577-62-<del>416</del>2 8/1/1947 Washington, D.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits s 23a or 28a-f shows ust be notified at X Yes 2 No Director Maryland Prince George's Camp Springs 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5608 Devon Court 20748 United States Funeral 7 is marked other than "natural", or items traumatic event, the Medical Evanture in traumatic event. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 1 ☐ Yes 2 ☐ Yo Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. 12 Attornev Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lawrence Williams Lois Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Joanne Williams / Wife 5608 Devon Court Camp Springs, Maryland 20748 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If iter any injury or oth once. Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan 6/20/2009 Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ule /Medical Due to (or as a consequence of): Examiner Ne Y Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trans Due to (or as a consequence of): attending physician for use as the burial Box 68760. The law requires that the death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate 2 🖭 No 1 □Yes 2. No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 □Yes 2 □ No 2 Accident Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide n 24 hours aft e Funeral DI letely filled in Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 29b. Signature and title of ceptifier 29d, Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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1 - For State Registrar

			1. Decedent's Name	(First, Middle	Last)								<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of	
	Physicia		PATRIC	IΑ	MARY	WILI	LIAM	S				J	June	14	2009	15:01	РМ
	/Medic	_	4a. Facility Name (II	f not institution,	give street and n	umber)			4b. City,	Town, or	Location	of Death		4c. (	County of Dea	th	
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	Funeral		5. Social Security No	umber	6. Sex			ast birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da April	th yYear)	9. Bir	thplace (State ountry)	or Foreign
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8	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	be T					- 1	16a Dece	dent's Usu	al Occup	ation		-	16b. Kir	nd of Business		
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12	withi iene. thar	E	Elementary/Second	ndary (0-12)	College	(1-4or 5+)	)	Admin	nistra	ator				Whit	e House	e	
b	filed Hyg Sther ent,	BeC	17. Father's Name (	(First, Middle, I	.ast)						18. Moth	er's Name	(First, Middle	, Maiden	Surname)		
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T.	shoul nd M mar mat	-	19a. Informant's Na				-	19b. Maili	ng Address	(Street					r Town, State,	Zip Code)	
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<u>a</u>	s 1 al f Hei item othe		20a. Method of Disp				20b. Pi	lace of Dispo emetery, cre	osition (Nam	me of	(e)	D	ate	20c. Lo	cation - City or	r Town, State	
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at		1 🔯 Burial 2 [ 4 ☐ Donation	☐ Cremation 5 ☐ Other (St	3 □ Removal from	m State	1	wood (				/18/2	2009	Fal1	s Churc	ch,Virg	inia
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ä	permit. Pages Department of Important: If its any injury or o		Val.		1200			11	102 W	.Broa	ad St					nia 220	46
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-44	Physician		Immediate Cause	(Final	only one cause or	n each line		Blee	a							Onset and	Death
	/Medical		disease or condition resulting in death)	'n	a. Due i	to (or as a			u	_						1	
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<b>B</b>	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events	ilijury S	С,												
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9 G.	w requires that the d been signed by the should be detached	Physic	9 Unknown					delin order administration			an in Dank		230 Did	tobacco i	se contribute	to the cause of	death?
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_ =	Physician: The law requires that the d r this certificate has been signed by the ral director, page 2 should be detached	Completed											pen 1 □ Yes	ormed? 2 🔼 No	death1 1 □ Ye	s 2 No	
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Division	or Ati fter d irect n by	Certification:	4 ☐ Homicide	determ	ined 28e. Pla	ace of Injur ilding, etc.	ry - At ho . <i>(Specif</i>	ome, farm, st	treet, factor	ry, office			City or To	(Street ar wn, State	e)	Rural Route Nu	mber,
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral		20a Cartifian	1 TV C = -416 -1-	ng Physician: To	the best -	of many law -	wlodge de-	th occurr	d at the t	ime data	and place	and due to th	e canse/s	and manner	as stated.	
	Hosp 24 ho Fune tely fi	Medical	29a. Certifier (Check only one)	2 Medical	Examiner: On th	the best of e basis of nanner stat	examina	wieuge, dea ition and/or i	investigatio	n, in my	opinion, de	eath occur	red at the time	, date an	d place, and d	ue to the cause	(s)
	thin 2	Med	29b. Signature and	title of cartific	and m	ialilier stat	ieu.		20	9c. Licens	se number			29d. Da	ite signed (Mq	nth, Day, Year)	
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	اد Registr			1 6 200		at .	A. ,	pare	-								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year **Physician** JUNE 2:25 PM ALEXANDER WEAVER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MAGNOLIA CENTER NURSING HOME PRINCE GEORGE'S LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB. 9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 □ F NORTH CAROLINA 1925 245-26-7410 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar in ust by notified at 1. Yes 2 No Director PRINCE GEORGE'S MD GLENN DALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20769 12405 RANSOM DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 2□No ARMY 10 Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐Yes 2 No Specify ⋧ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH LAB TECH PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be rent of Health and Mental is marked o ARTHUR WEAVER SUSIE CAMPBELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 Is
any injury or other trau 20769 MARGUERITE WEAVER/WIFE 12405 RANSOM DRIVE GLENN DALE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/16/2009 RIVERDALE CREMATORY RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JERKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed DEMENTIA burial-tra Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 😾 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the within To the 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 RAKESH ARORA M.D. 14300 GALLANT FOX LANE SUITE 222 BOWIE, MARYLAND 20769 31. Date filed (Month, Day, Year State JUN 1 6 2009

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 06-24-2009 Physician 0440 AM Cora Louise Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worchester Berlin Atlantic General Hospital 8. Date of Birth (Month, Day, Year) 02-12-1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 M 2 F 88 215-16-2763 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f shormust be notified at 1 ☐Yes 2 No Director Whaleysville MD Worcester 10g. Citizen of What Country? 10e. Street and Number USA 21872 8660 Whaleysville Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status d other than "natural", or Iten event. The Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White Specify. 2009 ≥ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 142100 Aircraft Armament permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other thi any Injury or other traumatic event, the once. Inspector 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry McCord Hazel Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) COO Jarrettsville, MD 21084 Foster A. Brown 1901 Furnace Rd (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery | 06-27-2009 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service License Inc. 610 W. MacPhail Rd BelAir, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Box 68760, attending physician The law requires that the death certificate be Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Vear □Yes 2 No 5 Other (specify) P.0. ned by the 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \bigcap \) Nursing Home \( 5 \bigcap \) Residence \( 6 \bigcap \) Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation М 1 □Yes 2 □No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

170

215-16

Brown

30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signat

J. van Egmord MD

31. Date filed (Month, Day, Year)

MIN 3 0 2009

D0056307

9733 Healthway Drive, Berlm, MD 21811

6-25-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Pearl M. Bailey 2009 June 1:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV . 11 Birthplace (State or Foreign Country) **Funeral** Days Year. Months Hours 1□ M 😾 F 213-26-8679 78 1930 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the "dedical Examiner must be mailled at 1 ☐ Yes 21 No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310A Tall Pines Court 21009 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2, TNo Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Space Telescope 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filiment of Health and Mental H ant: If item 27 Is marked ott George McCoy Lillian Frye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau once. Loccaine Rohrer / Sister 310A Tall Pines Court Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 30, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 2009 Woodlawn, Maryland 21. Signature # Funeral Service Licensee Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or example cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: signed by the attendin the detached for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown After this certificate has been si funeral director, page 2 should li Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No **Division of Vital** 1 ☐Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner at the time, date and place, and due to the cause(s) Medical

26, 2009

PEARL BAILEY

Registrar

completely

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JENNIFER HAUF, CRNP

30. Name and address of person who complete scause of death (Item 23a) (Type, Print)

32. Registra

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

6/26/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 2009 16:03 Godfrey W. Burns, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA Mercy Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06-08-54 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours XXM 2□ F Unk. Yrs. 55 217-60-3881 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1∏Yes 2□No Director Baltimore NA MD 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 21216 USA 3005 Normount Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African 1 X Never Married 2 ☐ Married Specify: American 1 □Yes 2 □XNo Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hyatt Regency Chef 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Burns Godfrey W. Burns, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 3005 Normount Court Baltimore, MD 21216 Janice Nesbitt-Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06-22-09 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licens 638 N. Gilmor Street Baltimore, MD 21217 from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pluse on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco us \_\_\_\_ ribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 es 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an 1 🗆 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. May of Death 28b. Time of 28c. Injury at Work? Date of Injury Certification: (Month, Day, Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Examiner The law requires that the death certificate be executed sician and burial-trans Box 68760, attending physician for use as the buria P.0. been signed by the should be detached Records, has page 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Wedical Examines must be notified at

**Physician** 

/Medical

4 🗌 Homicide

29a. Certifier

Medical

State

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayemore:

301 ST PAUL 31. Date filed (Month, Day, Year) JUN 3 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 PER PHATE G899 a 6/30/99 e Partment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 JUNE 25, **Physician** 1:30 P THOMAS BRETZIK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Abingdon 1441 Valley Forge Way | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | Oct. | 21, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 X M 2 □ F Pennsylvania 1932 76 205-26-1585 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6519 Alta Ave 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: ģ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Police Dept. Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Michael (unk) Bretzik Anna (unk) Fritz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any Injury or other troonce. Cynthia Maranto / Daughter 1441 Valley Forge Way, Abingdon, Maryland 21009 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary Byzantine Cem. 6-29-09 Nesquehoning, PA 21. Signature of Funeral Service Licenses 22 Name and Address of Facility.

McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-Stope **Physician** Liver year /Medical Due to (or as a consequence of): Examiner RRHOSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off PATITI Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 [] Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**1**√2 No Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) Daughter's ¥ER/Øutpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 1 Inpatient = 27. Manner of Deat 1 X Natural 2 Accident Residence 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 X No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Division of Vital Records, certificate completely filled in by the funeral director, this After after death n 24 hours a within 2 To the I

P.O. Box 68760,

Maryland

the

death with

ns 23a or 28a-f show

r than "natural", or Items The Wedical Examiner ma

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or Ite

within whental Hygiene. 7.27 is marked other than "ry traumatic even"

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 340 2009

KOTEISH

MD

LUHOT

ress of person who completed cause of death (Item 23a) (Type, Print)

CM

29b. Signature and title of certifier

30. Na and ad

barker

29c. License number

D60195

29d. Date signed (Month, Day, Year)

Boltmore

MD 212051

6-26-09

720 RUTLAND AVE #918\_

HOTKING HOIP

			For State Registrar	State of M	laryland		artment ( rtificate			iental H	ygiene Reg. No.	2000	20783
			Decedent's Name (First, Middle, I	_ast)						2. Date of D	eath		3. Time of Death
	Physicia /Medic		RITA	ANNA	BRO	NWC				JUNE	<u> </u>	2009 Year	2:00 P M
	Examin		4a. Facility Name (If not institution, g	_	)		4b. City, To		ocation of Death			County of Death	
- prefer	Francis		2714 Old Joppa  5. Social Security Number 6		ge (In yrs. la	st birthday)	If Under 1	Year _	If Under 24 Hrs.	8. Date of E (Month, I		9. Birth	place (State or Foreign
н	Funeral Director		214-14-5405	1□M 2\DF	87	Yrs.	Months   E	Days	Hours Min.	Oct. 1	4, $19$	921 Ma	ryland
	pu »		Usual Residence of Decedent  10a, State 10b, County		10c. City	Town or Lo	cation						10d. Inside City Limits
	/aryla	lor	Maryland Harfo	rd	Jop								1 □Yes 2X No
	r 28a-	Director	10e. Street and Number				10f. Zip Ci	ode			10g. Citi	izen of What Cou	ntry?
	h with	ai D	2714 Old Joppa	Road				085				SA	
336	be filed within 72 hours after death with the Maryland ntal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Marked Ever in a must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1	? <b>₹</b> No		Was Deceder If Yes, specify 1 □ Yes 2 □		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or I Rican, etc.)	No-	14. Race - Ameri Black, White, Specify: Whi	etc.
21215-0036	72 hou	ted	15. Decedent's			16a. Dece	dent's Usual (	Occupat	tion aring most of work	ina	16b. Ki	ind of Business/Ir	
21	rithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)				iring most of work		1 ~	m IIems	
CA	Hyg ther int, t		12 17. Father's Name (First, Middle, La	st)		HO	memake:		18. Mother's Name	e (First, Mida		wn Home Surname)	
Jan	should be land Mental s marked o	To Be	Otto (nmn) Land						Cecelia	(mmn)	Schu	ler	
Baltimore, Maryland	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic ev	_	19a. Informant's Name/Relationship						nd Number or Rur				
e, N	l and Health		Keith E. Brown	Sr. / Son	20h Pl				oa Road,	Date		y Lation - City or T	
201	ages 1 nt of h t: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3				sition (Name matory or othe		$\sin \cdot \frac{7}{1/2}$			-	Maryland
ij	permit. Pages 'Department of Important: If ite any Injury or of once.		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie		per				of Facility McC				
B	Depa Impo any Ir		Stephen Cl.	Mergls									nd 21009
-	Physician	1 - 5 - 6 -	23a. Part 1. Enter the disease, or co shock, or heart fallure. List or Immediate Cause (Final disease or condition	nly one cause on each	ed the death line.		4			,		) is ease	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequ	ence of):	AVI	01/1	No.	seas	p		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequ		/ ///	1					
	requires that the death certificate be executed teen signed by the attending physician and nould be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hu	A consequ	Hus	ian						
8760,	burial		Tobulang in docum, East	Due to (** s	a consequ	erice or).							
687	ificate g phys	edical		d	12-531			7/8			77		
Box	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			☐ Ectopic pre	gnancy			4	23d. Date of deli Month	very Day Year
O. E	ne dea the at hed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of de		Other (spec	cify)			-	World	54,
σ.	that the de ned by the detached		Part II. Other significant condition	s contributing to death	but not resu	Iting in the u	inderlying cau	use give	n in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
of Vital Records,	w requires that s been signed b should be deta	ed by								1	□Yes 2	□ No 3☐ Pro	obably 4 Unknown
eco	> 4 5	Completed								24a. W	itopsy	prior to c	topsy findings available completion of cause of
<u>E</u>	ician: The law certificate has b ector, page 2 sl	Соп								1 □ Ye	erformed? s 2 Dec	death? 1 ☐ Yes	2 🗆 No
VII;		Be	25. Was case referred to medical examiner?	Hospital:				Otho	26. Place of Dea			6 ☐ Other (Spec	-15.)
ō	ding Phys h. After this funeral di	7: 70	1 Yes 2 No 27. Manner of Death	28a. Date of In	itient 2 🗆 I	28b. Time o		c. Injury	at	28d. Descril	_		aiy)
ion	Attending r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Jay, rear)	Injury	М	Work′ 1 □ Y	r ′es 2 □ No				
Division	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director; completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		njury - At ho etc. <i>(Specif</i> y	me, farm, st	reet, factory, o	office			n (Street a Town, Stat		ral Route Number,
	Hospi 24 hour Funera tely fills	ledical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the bes	of examinat	wledge, dea tion and/or i	th occurred a nvestigation, i	it the tim	ne, date and place pinion, death occu	e, and due to rred at the tir	the cause( ne, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	and manner s	owieu.				number			ate signed (Monti	
	- > - O		> Kohert 1	Lit	den		D	38	933		06	129/2	009
			30. Name and address of person w	ho completed cause of	f death (Item	23a) (Type,	, Print)	, ,	14 100	0-1			2/5
			31. Date filed (Month, Day, Year)	ght, MD Renis	104 strar's Signa	Plv W7	ree K	_d	Ste 102	BE1 /7	nr, n	VID 216	""
	Sta Registr		31. Date filed (World, Day, Tear)	100	NA	. 190	Com						

		-	State of Ma	ryland / Depa <i>Cer</i>	artment of H rtificate of L			ene 3.No. 200	19 20781
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ye	3. Time of Death
	Physicia		Irma K. Becker				June 28 2		4:40 P M
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of D	
- de			2005 Taylor Avenue		Baltimor		O Data of Dieth	Baltin	OPE Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 219 18 3397 6. Sex 7. Age 1 1√2 M 2 □ F 85	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day)	923 Ba	Country)  1timore, Maryland
	ryland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	e Ma	cto	Maryland Baltimore	Baltimore			10	g. Citizen of Wha	X
	章 e e e e e e e e e e e e e e e e e e e	Die	10e. Street and Number		10f. Zip Code 21234		10	USA	t Oddinay .
	s 23a	eral	2005 Taylor Avenue	Ever in II S 13 1		isnanic Origin? (Sp	ecify Yes or No-		American Indian,
36	be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "natural", or items 23a or 28a-f show event, it is Medical Eventiner meat build filed at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent E  12. Was Decedent E  13. Tried Forces?  1 □ Yes 2 ★ Widowed  14 □ Divorced  Year or Dates:	10	Was Decedent of H If Yes, specify Cuba 1 □Yes 2⊠ No	Specify:	Rican, etc.)		Vhite, etc. White
21215-0036	72 hour "natural"	Completed t	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work		6b. Kind of Busin	ess/Industry
12	within ene. than	d E	Elementary/Secondary (0-12) College (1-4or 5 N/A	+)	e Operator	'/		lack & Dec	ker
CA	filed Hygid		17. Father's Name (First, Middle, Last)	1.0.		18. Mother's Nam	e (First, Middle, M	laiden Surname)	
lan	ld be lental ked c ic eve	To Be	Albert P Wiseman Sr			Henrietta	C Weller		
Maryland	s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than "other traumatic event, it e Me	-	19a. Informant's Name/Relationship (Type. Print)  Gary E Becker (Son)		ng Address (Street 2 Oak Forest				
re, l	is 1 and 2 of Health item 27 l		20a. Method of Disposition	20b. Place of Dispo	1.00			20c. Location - Cit	
imo	Page ment c ant: If ury or		XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Parkwood C	-	July 3 20		Baltimore,N	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signature of Funeral Service Licensee		<sup>2. Name and Addre assahn Fund 401 Belair</sup>			and 21236	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Care .	Physician			CUTE MY	Ocardia	1 Inc	WCTION		MINUTES
	/Medical		Due to (or as	a consequence of):					
	Examiner		Sequentially list conditions	THEYOSCLE	1150x				years_
	be:	ine	riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of.	. A				- NEOV
ó,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as	a consequence of):	207				
8760,	ate be ohysicia the bur	dical	d						
O. Box 6	eath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnan	су		23d. Date Mont	
σ,	s that th gned by e detacl	by Phy	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause gi	ven in Part I.			ute to the cause of death?
ord	equire en siç ould b	ted t					1 🗆 Ye		Probably 4 Unknown
Records,	aw asb 2st	Completed					24a. Was a autops perfori	sy pri med? de	ere autopsy findings available or to completion of cause of ath? ]Yes 2 □No
ita	ian: ' rtiffica ctor, p	Be C	25. Was case referred to medical				th (Check only on	A.	
ر ا	Physician: r this certific ral director, I			ent 2 ER/Outpatie	ent 3 DOA		lome 5 Resid		
n o	Ing PI	i.	27. Manner of Jeath 28a. Date of Injude 1 → 28a. Date	ury 28b. Time ( ay, Year) Injury	Wo	ıryat rk? ∐Yes 2 ∐No	28d. Describe h	ow injury occurred	3
Division of Vital	or Attending I ter death. irector: After n by the funer	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inbuilding, e	jury - At home, farm, st tc. <i>(Specify)</i>		lites 2 Lino	28f. Location (S City or Tow	treet and Number n, State)	r or Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical Ce	29a. Certifier  (Check only one)  (Check only one)  (Check only one)	of examination and/or i	ath occurred at the investigation, in my	time, date and plac opinion, death occ	e, and due to the curred at the time, c	cause(s) and mar date and place, ar	nner as stated. nd due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and:	29c. Licer	se number	2	29d. Date signed	(Month, Day, Year)
	F 3 F 8	1	Just .		Do	00)44(CC	4	6/20/0	٦
			30. Name and address of person who completed cause of Microsoft Street 8109	Hoose	e, Print)	SUITE E	Park	villa 1	~D
	St Regist	ate	31. Date filed (Month, Day, Year)  JUN 3 0 2009	rar's Signature	pe)		•		
	negis	1141	JOH JU ZUUS CENTRO	12. 17					

# Baltimore, Maryland 21215-0036

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		For State Registrar		aryiano /	•	tificate of	Death		Reg. No.	2009	20785		
Physicia /Medic		Decedent's Name (First, Middle, La     MARGARET	,	AUX				2. Date of Dea Month June	ath Day	Year 2009	3. Time of Death 5:25 p M		
Examine		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	or Location of Death	1	4c. C	ounty of Death			
		3902 BELLE AVEN 5. Social Security Number 6. S		e (In yrs. last	hirthday)	BA If Under 1 Year	LTIMORE  If Under 24 Hrs.	8. Date of Bir	th	N/A 9. Birth	nplace (State or Foreign		
Funeral Director		- 1	□ M <b>X</b> ⊠ F	78		Months Days	Hours Min.	8. Date of Bir (Month, Da Feb. 8	iy, Year) 193	Cou	ARYLAND		
yland now		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits		
a-f st	ctor	MARYLAND N/A			BA	LTIMORE					MXYes 2 □ No		
or 28	Director	10e. Street and Number		-		10f. Zîp Code			10g. Citiz	en of What Cou	untry?		
ath w	ra	3902 BELLE AV	T		1	212				U.S.A.			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ★Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 XX If Yes, Give Year or Dates:	_		Vas Decedent of I fYes, specify Cub I □Yes 2 <b>XX</b> No	dispanic Origin? (S ean, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Amer Black, White Specify:BLA(	, etc.		
72 ho	eted	15. Decedent's E	ducation ade completed)	1	6a. Dece	dent's Usual Occu	pation during most of wor	kina	16b. Kin	d of Business/I	ndustry		
vithin in ine.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	`life. L	OO NOT use retire	ed)						
iled w Hygie Ither ti nt, in	ပိ	12th grade   17. Father's Name (First, Middle, Last	3		DIET	ARY AIDE	18. Mother's Nan	ne (First Middle			MARYLAND		
d be fental	To Be	JOSEPH DUCKETT	,					E DUCKE					
shoul ind M i mari	Ĕ	19a. Informant's Name/Relationship	Type. Print)	1	19b. Mailir	g Address (Stree	t and Number or Ru			Town, State, Z	Tip Code)		
and 2 salth a		Brenda Breaux/Da	ughter		3902	BELLE A	VENUE, BA	LTIMORE	, MAR	RYLAND 2	21215		
bages 1 sent of He nt: If item		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.				sition (Name of natory or other pla	i	Date		ation - City or			
permit. F Departm Importar any Injur	4 Donation 5 Other (Specify) KING MEMORIAL PARK 07-02-09 B.  21. Signature of Funeral Service Cheensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FI										MARYLAND ME P.A.		
	_	23a/Part 1. Enter the disease, or com	plications that caused	the death. [							Approximate		
Physician /Medical		23a/Part1. Enter the disease, or som shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PANO	crea	tic	Cano					Interval Between Onset and Death		
Examiner		•	Due to (or as	a consequen	ce of):								
*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	a consequen	ce of):								
ecuted nd ransit	Examiner	Cause (Disease or injury that initiated events	C										
rifficate be executed og physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequen	ce of):								
cate b	edical	•	d										
death certine attending	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1   Yes   2   No 9   Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3	Ectopic pregnan	су		2	3d. Date of del Month	ivery Day Year		
that I	y Phys	Part II. Other significant conditions	contributing to death b	ut not resultin	ng in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?		
quires n sign	ed by							1 🗆	Yes 2	]No 3□ Pr	obably 4 Unknown		
aw red	Completed							24a. Was		24b. Were au	itopsy findings available		
The late has	mo;							auto perfo 1 □Yes	psy prmed? 2 No	death?	completion of cause of 2 □No		
clan: ertific	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only					
physic this c		1 Yes 2 No	·	ent 2 ER	<u> </u>	IL 3 LI DOA		dome 5 Res		- ' '	cify)		
ending Fath. or: After he funera	ation:	27. Manner of Death  1 S Natural 5 ☐ Pending 2 ☐ Accident investigation		ıry 28 ıy, Year)	Bb. Time o Injury	Wo		28d. Describe	how injury	occurred			
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj	ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location ( City or To	(Street and wn, State)	Number or Ru	ural Route Number,		
To the Hospital or within 24 hours afte To the Funeral Dir.	Medical	29a. Certifier (Check only one)  Check only one)  Check only one)	hysician: To the best miner: On the basis o and manner st	of examination	edge, deat n and/or in	h occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)		
To the within	Me	29b. Signature and title of certifier	w			29c. Licen	se number 78303	)	29d. Date	e signed (Monti	h, Day, Year)		
		30. Name and address of person who	completed cause of c	death (Item 23	3a) (Type,	701 N.	Charl	US SF	- 7	WING	N M)		
Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	60.1	11					-		
Registra		JUN 29 2009	HALKS 32. Registr	19. 1	goare								

amend #9,15,17,18&19a&b Per Ana BD G892 6730/09 JH

State of Maryland / Department of Health and Mental Hygiene

Amend Item 11 per spouse Certificate of Death 696293,7/1709, dk 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June 22, 2009 **Physician** 3:29 AM M Edward Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris Hospice 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Min. 1 🕅 M 2□ F Days 212-76-4310 51 Feb 15, 1958 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1y⊈Yes 2□No Director MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1631 N. Bradford Street 21213 USA Funeral 12. Was Decedent Ever in U.SUNK | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 21215-0036 'natural", or Specify: black 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 12 Custodian Private Industry Maryland 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) <del>-unk</del>-Be Doris Mae Williams Edward H. Brown Sr. ၉ Department of Health and Important: If Item 27 is ma 19a Informant's Name/Relationship *(Type Print)*  **David Brown/brother** <del>Stella Maris Hospice</del> 19b Mailing Address (Street and Number or Ruyal Route Number City or Jayn, State Zip Gode)
21093 2300 Dulaney Valley Road Timonium, MD 21093 Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) in state Trinity Cemetery 7/1/09 Dundalk, Maryland Ronald S. Wade 22. Name and Address of Facility hatman-Harris Funeral Home State Anatomy Board 55 Harris Funeral Home 3240 Reisterstown Rd. Baltimore, Md. 21215 23a. Part 1. En er the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limmediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn Vital 2**X** No 1 ∐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Pesidence} \) 6 \( \text{Normal Other} \) (Specify) 1 ☐ Yes 2 🙀 No Certification: To o HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Attending Division 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: d in by the t 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 0 within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examiner Nurse Practitioner ner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD.
22. Registrar's Signature JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State JUN 3 0 2009 Registrar

DHMH 17 Rev 1/2001

a.m.

UNE 22,

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar  1. Decedent's Name (First, Middle)		BUNCE	Cei	tificate of	Death	2. Date of Deat		009	3. Time of E	187 Death	
hysician /Medical	L	MARLENE E			JUNE		20 <b>6</b> 9	7:55A	М				
aminer		ta. Facility Name (If not institutio FREDERICK M	4b. City, Town, or Location of Death FREDERICK			4c. County of Death FREDERICK							
eral etor		5. Social Security Number  219-26-8125  Usual Residence of Decedent	6. Sex 1 □ M 2 ▼ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 21	Year) , 1938	9. Birth Cou Ma	place (State or ntry) ryland	Foreign	
	-	10a. State 10b. County 10c. City, Town or Loc				cation					10d. Inside City		
ecto	3	MD Frederick New Wind						1 Yes 2 No					
Funeral Director		10e. Street and Number 2825 Carlisle Drive				10f. Zip Code 21776			10g. Citizen of What Country?  USA				
nera	1	11. Marital Status unk  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Ye ar or Dates:			S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 □ Yes 2 No Specify:							
any injury or other traumatic event, the Medical Examinar must be routhed at once.  To Be Completed by Funeral Director	5												
		(Specify only highest grade completed)			(Give	ecedent's Usual Occupation Give kind of work done during most of working			16b. Kind of	Business/Ir	ndustry	unk	
	2	Elementary/Secondary (0-12) College (1-4or 5+)				life. DO NOT use retired) salesperson							
		17. Father's Name (First, Middle, Last)							irst, Middle, Maiden Surname)				
		Charles Oliver Bunce					Elea	Eleanora Ida Doerflein					
		19a. Informant's Name/Relations Patricia Dzie		riend				ural Route Numbe Stminster			ip Code)		
	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (6)			Place of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Locatio	n - City or T	own, State		
	t	21. Signature of Suneral Service				d 655 W.	Balti	more S	Street				
	Baltimore, MD 21201  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest								est,	Approximate Interval Between			
urial-transit uer uerical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  ORDINARY ALEXA 1/5						£			Onset and D		
		resulting in death)	13,	ey Disease									
	5	Sequentially list conditions,	ll 7 h	The									
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
		resulting in death) Last  Due to (or as a consequence of):											
dical			d				<u> </u>						
completely filled in by the functar director, page z should be detached for use as the buffar-transit.  Medical Certification: To Be Completed by Physician/Medical Examin		IF FEMALE: 23b. Was decedent pregnant		yes, outcome of pregnancy					23d. Date of delivery				
	2	in the past 12 months?				Ectopic pregnand Other (specify) _	cy		Month Day Year				
		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u				nderlying cause gi	23e. Did to	3e. Did tobacco use contribute to the cause of death?					
	2					, , ,	1 □ Yes			2 No 3 Probably 4 Unknown			
							24a. Wa						
							autopsy performed 1 □ Yes 2 ②			prior to completion of cause of death?  No 1 Yes 2 No			
	3	25. Was case referred to medical examiner?					26. Place of Death (Check only one)						
	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of				I 3 DOA	t 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at 28d. Describe how injury occurred						
		1 Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation			Work?   M								
		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offic building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	5	29b. Signature and 1945) of certifier				29c. License number			29d. Date signed (Month, Day, Year)				
Medical C		· IN DE				57131			6/22/09				
		* LO &				57	7/31		6/2	2/0	9		
		30. Name and address of person	n who completed caus	se of death (Iten	n 23a) (Type,	Print)	713) 1c /		6/2	2/0	9		

09-04289

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene James T. Brewster Certificate of Death 1- For State Reg. No. <u>Registrar</u> 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 29, 2009 Year 1535 hrs Medical Examiner James T. Brewster 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Forest Heights 124 N. Huron Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 1956 Germany Mar 24, 214-72-3768 1 X M 2 F 53 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Prince George's Forest Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 USA 124 n. Huron Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 1 X Yes If Yes, Give Year 175-79 4 X Divorced Yes 2 X No specify: white Widowed è 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) steam fitter HVAC 0 12 18.Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be Lynwood Buell Brewster Mary Elizabeth Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Kimberly Brewster/former spouse 21921 23 Breon Lane Elkton, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State 2 Cremation 3 portant: Denation 5 X Other Specify: in state Baltil
permit. I
Departm
Importa 22. Name and Address of Facility 21. Signature of Funeral Service Ronald State Anatomy Board Baltimore, MD 2120 655 W. Baltimore Street ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ilure. List only one cause on each line Medical a, Contact Gunshot Wound of Submental Region ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical g physician a AMENDED UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the Year Ectopic pregnancy Month attending l Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify, Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? as been signed by t should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? No 1 🗸 Yes 2 ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical of Vital æ Other<sub>4</sub> examiner? Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 2 Inpatient this 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Subject shot self FOUND Division Natural 1 Yes 2 ✔ No Pending the May 29, 2009 1535 hrs Certificat 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 124 N. Huron Street, Forest Heights, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 30, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner Registrar's Signature State

Registra

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of F			ene 2009	20789
	*		Decedent's Name (First, Middle, I	_ast)				2. Date of Death Month	Dav Year	3. Time of Death
	Physicia /Medic		Francis R. Baak	ie				June 12	, 2009	7:45 AM M
	Examin	_	4a. Facility Name (If not institution, g			4b. City, Town, o		ıth	4c. County of Dea	th
			3013 Echodale A	. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		9. Bin	thplace (State or Foreign
	Funeral Director		145-18-3278	1≅M 2□F 8		Months Days	Hours Min	July 24,	1925 Net	w Jersey
	p.		Usual Residence of Decedent  10a. State 10b. County	100 G	ty, Town or Lo	anting				10d. Inside City Limits
	shov	ក	MD Howard		•	mbia				1 ☐ Yes 2¶ No
	28a-f	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	3a or	D	9266 Lapwing Co	urt		210	)44		USA	
	death	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whi	
36	72 hours after death with the Maryland natural; or items 23s or 28s-f show digal Examinat must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	If <del>Y</del> es, Give		1 ☐ Yes 2🎇 No			Specify: Wh	nite
8	thour	ed b	15. Decedent's	Education	16a Dece	dent's Usual Occup	ation	orking unk	6b. Kind of Business	/Industry
212	hin 72	plet	(Specify only highest ( Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of we d)	orking GIII		
21	ed wit ygjene ygjene ksr tha t, tha	Con	12	4				(m) 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	food ser	vice
and	ntal H nd oth	Be	17. Father's Name (First, Middle, La Charles Cheste					ame (First, Middle, M e McAllis		
<u> </u>	hould id Mei mark matic	ပ္	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street		Rural Route Number,		Zip Code)
<b>≥</b>	nd 2 sulth an 27 is reau		Janet Broening/f		1075	2 Freder	ick Road	Ellicott	City, MD	21042
ore,	of Hear item		20a. Method of Disposition			osition (Name of matory or other pla	ce)	Date 2	0c. Location - City or	r Town, State
<u><u>E</u></u>	Page ment ant: If ury o		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe	cify)						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene is the propriation of Health and Mental Hygiene Pratural; or items 28a or 28a-f show any protant: if item 27 is marked other than "natural; or items 28a or 28a-f show any protant; or other traumatic event, tra Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice Ronald S	. Wade Ditecto	r S	<sup>2. Name and Addre</sup> tate Anat altimore,	omy Boar	rd 655 W.	Baltimore	Street
	j. 3		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the dearnly one cause on each line.	th. Do not en	ter the mode of dy	ng, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. AVANCED	SENILE	E DEMEN	TA.			
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
¥	* 75 a	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):					
	cuted nd ransit	Examiner	that initiated events	с						
Ö,	be executed iician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	icate be executed physician and s the burial-transit	dlcal	,	d						
9 x	death certificate e attending phys d for use as the	/Wed	IF FEMALE:	23c. If yes, outcome of pregn	ancy				23d. Date of de	elivery
Вох	atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic pregnanc □ Other (s <i>pecify)</i> _	у		Month	Day Year
0	by the stached	hys	9 Unknown	9□ Unknown						
	gned ge de	ρ	Part II. Other significant condition	s contributing to death but not re-	sulting in the t	underlying cause gr	ven in Part I.		/	to the cause of death?  Probably 4 □Unknown
Records,	w requir been si should I	Completed						-		
zec	has the spanning of the spanning spanni	mple						24a. Was a autops perforr	y prior to death?	
la		e Co	25. Was case referred to medical				De Blace of D	1 ☐ Yes 2 eath (Check only on	2 1 No 1 □ Ye	es 2 No
Vital	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ot			4	ecity is set DUVIN
n of	ding Phy h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe ho	w injury occurred	
Siol	Attending r death. ector: Alte by the fune	catle	2 Accident investiga 3 Suicide 6 Could no	ation later			Yes 2 No			Court Court Alexander
Division	2 2 2 2	Certification:	4 Homicide determin		nome, farm, s ify)	treet, factory, office		City or Town	reet and Number or I n, State)	nurai noute Number,
_	Hospital		29a. Certifier 1 Certifying	Physician: To the best of my kn	lowledge, dea	th occurred at the t	me, date and pla	ace, and due to the ca	ause(s) and manner	as stated.
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	(Check only 2 Medical E.	xaminer: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death oc	ccurred at the time, d	ate and place, and di	ue to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	110		29c. Licen	se number	2	9d. Date signed (Mo	
			> cuagradoa				- W(-)		viene 14,	00/
			30. Name and address of person w	000 00111 50	PARILLA 1	1 /2111	E DR. 1	VOTTINGHAM	n MD 21	236
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sin	nature	les !	/		/	
- A	Regist		JUN 3 0 200	9 Cenus A.	Mari					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 6:25 AM DORIS AUGUSTA GOSNELL BERNHARDI 2009 /Medical June\_ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County OAK CREST VILLAGE HEALTHCARE CENTER Parkville 8. Date of Birth (Month, Day, Year) Nov 13, 19 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 93 218-01-2210 **Director** Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🕅 No Directo Parkville Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8800 Walther Blvd. 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Aerospace Industry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Murray Edward Gosnell Nellie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any Injury or other trace Kevin P. Higgins, Sr. 571 Woodbine Avenue, Towson, Maryland 21204, of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/29/2009 Baltimore, Maryland 21. Signatury (Furnar I Savijo Linear) ee Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant neoplasm of abdomen 1 year /Medical Due to ( as a consequence of): **Examiner** Sequentially list conditions, in any, is aumy to minus list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence offi-Exami Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensive HearT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760 Division of Vital Records, ERN#ARD.

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page 2 should be detached for

funeral

filled in by the

Medical

d 2 should be fi th and Mental H

event, the Medical Exeminer must be notified at

within 24 hours after death.

To the Funeral Director: After this certificate To the Hospital or Attending

> State Registrar DHMH 17 Rev 1/2001

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

R171944

125/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KNP 8800 Walther Blvd, Packville, MO, 21234

29b. Signature and title of certifier

29a, Certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 28 Doris W. Bruns June 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Agnes Hospital Balt imore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/21/1925 Birthplace (State or Foreign Country) 6. Sav 5. Social Security Number 7. Age (In vrs. last birthday, Months Days Hours Min. 1 □ M 2√□ F 213 20 9119 MD 83 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes ¾☐ No Director MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2530 Kensington Gardens Unit 406 21043 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Helweick Dora M. Keil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21\overline{043}$ 19a. Informant's Name/Relationship (Type. Print) John A. Bruns, Sr. — husband 2530 Kensington Gardens Unit 406 Ellicott City,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery: 07/03/09 Ellicott City, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee M01044 Thim Collis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic days r as a consequence of): Due to ( small bove chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se a consequence off Perforated Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred . Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

that the death certificate be executed Division of Vital Records, P.O. Box 68760, and burial-trar as attending nse for t detached Dorig page 2 s To the Hospital or Attending Physician: director, within 24 hours after death

To the Funeral Director:
completely filled in by the

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Page Department o Important: If any injury or

**Physician** /Medical

Examiner

6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W.

29c. License number AS24385284106 29d. Date signed (Month, Day, Year) 28 109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pazoglou, MD Nicholas

900 Caton Ave Baltimore, MD

State Registrar 31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician**  $\mathbb{P}^{\mathsf{M}}$ JUN 26 2009 4:32 CHARLOTTE LUCRETIA BOWERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, . 1929 **Funeral** Months Days Hours 1 □ M 2 🛛 18, Pennsylvania August 159-24-2908 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 503 Gilscot Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Paclawski Anna Pastuch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 503 Gilscot Place, Rockville, Maryland 20852 Richard R. Bowers / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate Heaven of Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 Robert A. Pumphrey Funeral Home / Ro 300 West Montgomery Avenue, Rockvil 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** SYRINGOMYELIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1∐Yes 2¶∏No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number 0101231164 (VA)

201

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician:

and

certificate

show

within 72 hours after

12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r

Baltimore, Maryland 21215-0036

State Registrar 30. Name and

ddress of persor

NATIONS LCDR MC JOEL. e filed *(Month, Day, Year)* JUN 3 0 2009

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

NATIONAL NAVAL MEDICAL

BETHESDA MD

20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Davi	d Bernhardt	1	- For State	tate of Marylan		tment of <i>ificate of</i>		d Ment	al Hyg		g. No. 2	00	9 2079
	Physicia		Registrar 1. Decedent's Name (First, Mid	dle,Last)					1	Date of Deat Month	Day Year		3. Time of Death 1407 hrs
Med	dical Exami	ner	David	Bernhardt			ldwin			June 28, 2	4c. County o	f Death	1407 185
1			4a. Facility Name (if not institut 7948 Saint Bridget L	_	ber)	1	4b. City, Town, or Dundalk	Location of	Death		Baltimore		nty
			5. Social Security Number		. Age (In yrs. las	st birthday)	If Under 1 Yea	r If Under	r 24Hrs.	8. Date of Birt	h(MM/DD/YYYY)	g. Birth	place (State or
	Funeral Director	- 1	215-90-2733	1 1 MM 2 F			Months Day	_	Min.	Toll much	27,1964	Foreign Cou	
		L	Usual Residence of Decedent	1_/WM 2_F	45	) IIS				resouxu	1 21,1704		
	any	1	10a. State 10b. County	/	10c. City, T	Town or Locat	tion						10d. Inside City Limits
	. ≰	٦	Maryland Bal	timore		Duna	talk						1 Yes 2 XNo
	Aaryla 28a-f 1 at o	اق	10e. Street and Number				10f. Zip Code	222		11	0g. Citizen of Wh	at Count	try?
	ith the Maryland s 23a or 28a-f show a s notified at once.		7948 St. Bridg			<del></del>		222	:-2 / C- o	eif. Van as No	USA	- Americ	can Indian, Black,
	th wit cms 2 rt be n	Funeral	11. Marital Status 1 Never Married 2			5. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Orig n, <b>M</b> exican,	Puerto R	ican, etc.)	White		arr morari, Brack,
	er dea			1 Yes livorced If Yes, Give Year	2 X No	1	Yes 2 No	specify:			Specify:	Whi	te
	ırs aft tural"	d by	15. Decedent's Education (Sp	or Dates:	completed)	16a. Decede	nt's Usual Occupa	tion (Give I			16b. Kind of Bu	siness/Ir	ndustry
	72 hor	eted	Elementary/Secondary (0-12	College (1-	4 or 5+)		nost of working life		use retire	u)	C. a		
	5-0036 iled within 72 Hygiene. I other than the Medical	Comp	12 years			Maci	rine Ope			First Middle	Steel Maiden Surname		
	Hygin d other		17. Father's Name (First, Midd							M. Gol		,	
	2121 unld be fi Mental marked c event,	o Be	Thomas A. Bal			19b. Mailir	ng Address (Stre	et and Num	nber or Ru	iral Route Nur	mber, City or Tow	n, State.	, Zip Code)
	nore, MD 21215-00 ages I and 2 should be filed wi nt of Health and Mental Hygies tt: If item 27 is marked other other traumatic event, the M	ဥ	Marilyn M. Bal		other	1	St. Brie						
	e, N I and Health Health item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of co	emetery,	Juli	Date 2	20c. Location	- City or	Town, State
	nor ages ant of nt: If		1 X Burial 2 Cremat		m State Mo	reland	Memoria	l	20	009	Baltim	ore,	Maryland
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Donation 5 Other     Signature of Funeral Servi		0 0	22	Name and Address Onnelly 110 Soll	Funen	al He	ome ol	Dundalk	. P. A	
	in In Deg		Chithon	1 Come	lly	7	110 Soll	ers P	oint	Road,	Dundalk	<u>, Md.</u>	21222 Approximate Interval
	Physician		23a. Part I. Enter the disease, failure. List only one cau	se on each line.	V		the mode of dying	g, such as c	cardiac or	respiratory ar	rest, shock, of fie	art	Between Onset and Death
1	√Medical ′xaminer		Immediate Cause (Final disea or condition resulting in death	se a Dilated Card									Bouin
				Due to (or as a	consequence of								
н		Je.	Sequentially list conditions, if any, leading to immediate		consequence of	f):							
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	uted nd ransit	Ä	events resulting in death) La.	d									
	be executed sician and urial - trans	edical	UNPENDED	AMENDED									
		) Š	IF FEMALE: 23b. Was decedent pregnant i	. 10	outcome of preg		- 1-1-1	Ecton	ic pregna	nev	23d. Date of Month		y Day Year
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	s, P.O nires that to n signed by d be detac	ed by								24a. Wa	-		utopsy findings available
	ords w requ	Completed								auto	opsy formed?		completion of cause of
	Reco	E	İ							1 🗸 Yes		1 🗸 Y	es 2 No
	Vital Recysician: The his certificate director, page	Bec	25. Was case referred to med examiner?	Described to the				Other			D ::	o d Oah	
	of Vital Records, ng Physician: The law require After this certificate has been si meral director, page 2 should b	0	1 ✓ Yes 2 No		npatient 2	ER/Outpatie		njury at Wo		g Home 5	Residence 6 e how injury occu		er: Scene
	ding Phy After tl	;;	27. Manner of Death  1  Natural 5	28a, Date (Month	, Day,Year)	200. Time 0		Yes 2			, ,		
	Division tal or Attendia rs after death al Director: A led in by the fu	Certification:	2 Accident	nvestigation 28e Plac	e of Injury - At h	ome, farm, st	reet, factory, offic	e building,	etc.	28f. Location	(Street and Num	ber or R	ural Route Number, City
In	Divi	1 =		Could not be letermined (Specify)						or Town	, State)		
7	Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,		4 Homicide 29a. Certifier 1 Certifyin	. Bloodeless Table has	at of my knowles	ige, death oc	curred at the time	date and p	olace, and	due to the ca	use(s) and mann	er as sta	ated.
6	o the lithin 2. The F	Medical	(Check only one) 2 Medical	Examiner: On the basis	of examination a	and/or investi	gation, in my opin	ion, death o	occurred a	at the time, da	te and place, and	due to t	me cause(s)
	Ĭ.≚ <u>F</u> . S	ĕ	29b. Signature and tive of oe				1	ense numbe	er		1		onth, Day,Year)
				// ~	_		0.0	C.M.E.			June 29,	2009	
	CONT		30. Name and ad 1 s of per	The second secon			144 D 01	ot Delti	more A	4D 21201			
	OCME		Mary G. Kipple MD				11 Penn Stre	et, Baitii	nore, N	112 Z 120 I			
		State	31. Date filed (Month, Day, Y	100 A 32.R	egistrar's signa	ture							

	Trogistial	1/ Department of Health and Mental F 2,06/30/09dhb Certificate of Death	1.075
Physician	1. Decedent's Name (First, Middle, Last)  Daniel Burwell	2. Date of Month	Death Day Year 7:39PM
/Medical Examiner	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL	4b. City, Town, or Location of Death	4c. County of Death
Funeral Director	5. Social Security Number 183–26–4453   6. Sex 1 M 2 □ F   7. Age (In yrs. la		Birth Day, Year) 7, 1934  9. Birthplace (State or Foreign Country) NC
Maryland f show		Town or Location TIMORE	10d. Inside City Limits 1 <b>X</b> Yes 2 □ No
fier death with the Mar ritems 23a or 28a-f sl thing must be rediffed Funeral Director	10e. Street and Number 820 S. CATON AVENUE	10f. Zip Code <b>21229</b>	10g. Citizen of What Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be routified at once.  To Be Completed by Funeral Director	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces? 1 Yes, 2 X No If Yes, Give Year or Dates:	if Yes, specify Cuban, Mexican, Puerto Ricán, etc.)  1 □Yes 2█ No Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: <b>Black</b>
Maryland 21215-0036 of 2 should be filed within 72 hours aft the and Mental Hygiene.  27 is marked other than "natural", or traumatic event, the Medical Examiration of the Medical Exa	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry <b>Unk</b>
yland 2 July be filed Mental Hyg arked other attic event,	17. Father's Name (First, Middle, Last)  Daniel Burwell, Sr.	18. Mother's Name (First, Mid Ruth Rogers	
Mary nd 2 sho lith and 1 27 is mad r traums	19a. Informant's Name/Relationship (Type. Print)  Danielle Burwell	19b. Mailing Address (Street and Number or Rural Route Nu 5200 Lewis Road, Apt.,33 Sa	
Baltimore, oernit. Pages 1 an Department of Heal mportant; if item 2 any Injury or other once.		ace of Disposition (Name of Date metery, crematory or other place)	20c. Location - City or Town, State
Balti permit. Departn Importa any Inju	21. Signature of Funeral Service Licensee  Gerrod F. March per DVR	22. Name and Address of Facility IIAM 123  Jessup, PA 18434	
Character by Physician (al-transit Examiner Examiner Examiner Examiner Examiner Examiner Examiner Physician (al-transit examiner	23a. Par11. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	10 MI A ence of):	y arrest, Approximate Interval Between Onset and Peath
876 876 cate be cate be	resulting in death) Last  C.  Due to (or as a consequence)  d.	ence of):	
A M. Box death cer e attending of for use	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
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JELL  al Record  The law requir cate has been s page 2 should	TYPE 2 DM	p	prior to completion of cause of death?
URUEI n of Vital Rec ng Physician: The law fler this certificate has neral director, page 2 on: To Be Compl	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Nopatient 2 TE	26. Place of Death (Check on Other:	ly one)
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Division Division of the property of the prope	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	M 1 □Yes 2 □No  ne, farm, street, factory, office 28f. Locatio City or	n (Street and Number or Rural Route Number, Town, State)
To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	vledge, death occurred at the time, date and place, and due to on and/or investigation, in my opinion, death occurred at the tire	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of sertifier  MD	29c. License number P 2 2 2 5 3	29d. Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  5/11/09
	30. Name and address of person who completed cause of death (Item	23a) (Type, Print) 900 S CATON AV T	BALTIMORE 21229
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signate  JUN 30 2009		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G892, 6/30/09, WS
State of Maryland / Department of Health and Mental Hygiene

			For State	State of Maryl		irtment of Healt		Hygie	ne	21. 22. and 25. East
			Registrar  1. Decedent's Name (First, Middle, La.	st)	Cei	rtificate of Dea		Reg. of Death	No. 2 11 19	3. Time of Death
н	Physici		Doris Elizabeth				Mon		Day Year	9:45A M
4	/Medio Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or Locat			4c. County of Death	1
mark.			3509 Northway Di	ive		Parkvill			Balt:	
	Funeral		Social Security Number     6. S	□M oXTE	yrs. last birthday) Yrs.	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8. Date urs Min. (Mor	of Birth oth, Day, Ye	9. Birth	place (State or Foreign ntry)
	Director		214-12-4549 Usual Residence of Decedent	89			Febr	uary	13,1920 V	irginia
	yland		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Sa-f si	ctor	Md Balt	imore	Parky	ville				1 □Yes 2 ŪNo
	# P 28	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Coul	Ť
	sath w	eral	3509 Northway Di	12. Was Decedent Ever	in II C 12 1	2123		or No.	USA 14. Race - Ameri	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Michigal Engining must be recilled at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Nas Decedent of Hispanion of Yes, specify Cuban, Medin of Yes 2 ⊠ No Specify Cuban of Specify No S		tc.)	Black, White, Specify: Wh:	etc.
5-0	72 ho 'natui	Completed	15. Decedent's Ed (Specify only highest gra	fucation ade completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b	. Kind of Business/In	dustry
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	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a cor	perte	ation				
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			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)				
	- 64-	to	Panayiotis A. Ba	tatzis 8113		d Rd. Suite	100 Baltin	ore,	Md. 21234	
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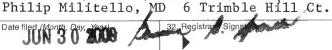
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 26,2009 8:15P **Physician** Joseph P. Ciattei /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Holly Hill Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Hours | Min. | May 30, 1924 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary Land 85 Director 216-16-1504 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 💟 No Director Nottingham Balto. Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 36 Whips Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. <sup>2□</sup>1943-1945 within 72 hours after 1 Never Married 2X Married White Maryland 21215-0036 1 ☐Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Accountant d 2 should be filed w. th and Mental Hygier 7 is marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Colomba Monaco Nicola Ciattei ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is r any injury or other traur Nottingham, Md. 21236 36 Whips Lane Spouse <u>Evelyn Ciattei</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City 6-30-2009 Gardens of Faith 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home Busin all Nottingham, Md. 21236 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Right Femur Fracture disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be execute burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔼 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗆 Yes 800 A FALL To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident MARCH 27, 2009 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Boute Number City or Town, State) 36 W/11/P 3 L Mary 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide HOME NOTTINGHAM. MO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Lutherville, Md. 21093

D18667

29d. Date signed (Month, Day, Year)

JUNE 29,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** CARTER MARY 6-20 AM JUNE 2009 25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ebrew Convelesent Leute Hmore lp evinda Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours 1 M 25 218-14-2045 Mary land 31. Director ban Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rai", or Items 23a or 28a-f show Examiner must be notified at 1 Tyes 2 No Director 1 more 10e. Street and Number 10g. Citizen of What Country? Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 2 10 1 ☐ Yes 2 № If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Black ģ 4 Divorced 3 Nidowed Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 1d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname reer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Department of Health an Important: if Item 27 is any injury or other trauons. Bourne-daughter Baltimore, 506 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nationa 21. Signarture of Funeral Service Licensee 22. Name and Address of Facility Howell Liberty Hights Ave, Balto 4600 MD 21267 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCEN DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 RESPIRATORY 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No page 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 3□ DOA 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospitai 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) evav D0068394 PHYSICIAN 06/26/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 🗸 EVINOPLE ALPNA ASNAWI 2434 W. BELVEDERE AVE BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 3 0 2009 Registrar

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Baltimore, permit. Pages l at Department of Hee Important: If ite	o ć	V	1. i ature Funeral Se	e Licens	ee /		2	<ol> <li>Name and Add McComas</li> </ol>	ress of Facilit Funera	al_Home,	P.A.	100	- 21000	, "	
<b>Q</b> 5 5 7	Ē	1	Mulls // 23a. Part I. Enter the disease,	104	/			1 2 2 7 7 7 1		7 17~ 10~	7 1000	shook, or hea	art Ap	proximate Interval	
physicia		T	<ol> <li>Part I. Enter the disease, failure. List only one cau</li> </ol>	or compli se in e	tions that hine.	caused the dea	ith. Do not en	er the mode or dy	1119, 3001 00	1			Be	etween Onset and Death	
ledic kamin	-		Immediate Cause (Final disea	ise a.H	ypert	ensive	athero	scleroti	c card	liovascula	ar a	isease			
Aaiiiii	ŭ		or condition resulting in death	) [	Oue to (or as	a consequence	e of):								
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		<u>۽</u>	cause. Enter Underlying Cau	se c							_		_		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	for use as the bu		IF FEMALE: 23b. Was decedent pregnant i	in the		s, outcome of po birth	regnancy 2	Fetal death	3 Ector	pic pregnancy		Month	Day	Year	
68 certifi	ise as	ļä.	past 12 months?		-	gnant at time of		Other (Specify,	)						
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C. E. E. E. Dy th	detached	Phy	Part II. Other significant co	nditions	contributing	to death but n	ot resulting in	the underlying ca	use given in	Part I. 23e				y 4 🗸 Unknown	
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the Tas After this confificate has been signed by	10 the function Director: After this confined has been against completely filled in by the funeral director, page 2 should be detailed.	S	25. Was case referred to me	dical				26.	Place of Dea	ath (Check only one)					
ician:	rector	Be	examiner?		Hospital: 1	Inpatient 2	ER/Outp	atient 3 DO	Other 4			Residence 6		cene	
F Vi	ral di	ို	1 ✓ Yes 2 No 27. Manner of Death		28a. Da	ate of Injury		ne of Injury 28	c. Injury at W	ork? 28d. De	scribe h	ow injury occu	irred		
n o ding h.	fune	Certification:	( V	Pending	(Mo	onth, Day,Year)	- 1		Yes 2						
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Division Hospital or Attend 24 hours after death	ed in	rtifi	Saloice =	Could not determine	be					\	10001, 01				
Ospite hour	ly fill	ပိ	4 Homicide 29a. Certifier 1 Certifiving	na Physic	ian: To the	best of my know	wledge, death	occurred at the ti	me, date and	place, and due to t	he cause	e(s) and mann	ner as stated.	auce(c)	
the H in 24	plete	Medical	(Check only one) 2 Medical	Examine	r: On the ba	sis of examinati	ion and/or inv	estigation, in my o	pinion, death	occurred at the tim	e, date a	p			
To the	COLL	Med	29b. Signature and title of co	ertifier	and mann	er stateu.		29c.	License num	ber			gned (Month	i, Day, Year)	
	1		his h	1	n	5			O.C.M.E.			June 24,	2009		
	ľ		30. Name and address of pe	arson who	completed	cause of death	(Item 23a)								
641			30. Name and address of per Ling Li, MD Ass	sistant I	Medical E	xaminer	111 Penn	Street, Baltim	ore, MD 2	21201					
	2	tate	at Date Clark (to Day)		_	. Registrar's Si	gnature	4							
Re	اد egis		11111 - 0 1	2009	1	und .	9 100	Red			_				
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Dillylli I/ PG	J+ 1/2						4.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day CLARKE 6-47AM **Physician** BERNARD 2009 une /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A HOSPITAL Son Secours If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 2, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** <sup>Year)</sup> 1967 Hours Days Months 1X M 2□ F Maryland 41 214**-**64**-**6709 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, 11 and 25 and 12 aminer must be notified at 1X Yes 2 □ No N/A Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 208 S. Payson St. 10f. Zip Code within 72 hours after death with 21223 USA Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "na any Injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) N/A (disabled) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Charles Clarke, Sr. Loretta F. McDaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 S. Payson St. Baltimore, MD. 21223 19a Informant's Name/Relationship (Type. Print)
Loretta F. Clarke, mother 20b. Place of Disposition (Name of competery, crematory or other place)

Loudon Park Cemetery 06-29-2009 20c. Location - City or Town, State 20a. Method of Disposition

14∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Ambrose Funeral Home, Inc.
—1328 Sulphur Spring Rd. Arbutus, 21. Signature of Funeral Service Licenses 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final doys Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi 000 nes 650 Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) P.O.1 1 □Yes 2 □ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 2 Yes 2 □ No 2 □ No 1 X Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

State Registrar

31. Date filed (Month, Day, Year) JUN 3 0 2009

29b. Signature and title of certifier

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AEEM 32. Registrar's

M Nocem MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

olphin st

29d. Date signed (Month, Day, Year)

Boltimere MD

June 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CALARCO Dav Year **Physician** ACQUELINE 06 2009 27 A M /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marylan University 0 Ba IS A LTIM O'CO 7. Age (In yrs. last birthday) 78 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)

WEST **Funeral** Year) Hours Min. 234-44-8587 Months Days **Director** 03/05/1931 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exertings must be notified at Director MD Baltimore Halethorpe 1 ∐Yes 21X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2922 Illinois 21227 Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 □Yes 2 No Specify: þ white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, The Mes Elementary/Secondary (0-12) College (1-4or 5+) 10 Home maker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Porter Wolfe Callie Billips ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald S. Sauerhoff-son 2922 Illinois Avenue Halethorpe MD 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 6-26-2009 Glen Burnie MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne alliva Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician therositere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of t Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760 physician as the b IF FFMALE for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 KNo detached ss been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1 □ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stat 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year) 082050L

State Registrar

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30. Name and address of person w

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o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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900 S. CATON AVENUE, BALTIMORE

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ky Cameron C	Jilale	1- For State	artment of Health and Mental H rtificate of Death		19 2080
Physic	ian/	Registrar  1. Decedent's Name (First, Middle,Last)	inicate of Death	Reg. No.  2. Date of Death	3. Time of Death
ledical Exam		Sky Cameron Chaleff		Month Day Year June 25, 2009	0820 hrs
}		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		h
<b>5</b>		8836 Willowwood Way  5. Social Security Number 6. Sex 7. Age (In yrs. I	Jessup  last birthday)   If Under 1 Year   If Under 24Hrs	Howard  8. Date of Birth(MM/DD/YYYY) 9. B	rtholece (State or
Funeral Director		5. Social Security Number 556-49-5465 6. Sex 7. Age (In yrs. I	Months Days Hours Min	Fore	gn
		Usual Residence of Decedent	Yrs.	Jan. 3, 1970 °	ountry) CA
, any		10a. State 10b. County 10c. City	, Town or Location		10d. Inside City Limits
Maryland 28a-f show d at once,	ō		essup		1 Yes 2 XNo
e Mary or 28a- fied at	Director	10e. Street and Number 8836 Willowwood Dr.	10f. Zip Code 20794	10g. Citizen of What Co	untry?
with the Maryland ms 23a or 28a-f sho be notified at once.		11. Marital Status 12. Was Decedent Ever in U	I.S. 13. Was Decedent of Hispanic Origin? (Sp	USA	rican Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		Trout march, Black,
after d	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify:	White
hours a		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		/Industry
36 hin 72   e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Software Programer	Governmen	a+
21215-0036 ould be filed within 72 I Mental Hygiene, marked other than 's	ĕ	17. Father's Name (First, Middle, Last)	0	(First, Middle, Maiden Surname)	.IL
21215 1d be file Mental H.	Be	Ira Jay Chaleff	Sally	Ackerman	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23s or 28s-f sh matic event, the Medical Examiner must be notified at once	ဥ	19a Informant's Name/Relationship (Type, Print ) Ira Jay Chaleff, father	19b. Mailing Address (Street and Number or F		
Malth 2 Mark			9621 Hillridge Dr. Place of Disposition (Name of cemetery,	Kensington, MD.  Date 20c. Location - City of	20895
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Purial 2 X Comption 2 Pamoual from State	crematory or other place)		
Baltimore permit. Pages 1 Department of H Important: If i		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	- 1	-29-2009 Glen Burn	ire, MD
Ba perm Depz Inp			22. Name and Address of Facility Ambrose Funeral H 1328 Sulphur Spri	ome, Inc.	Ф 01007
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ospita hours uneral	Certific	4 Homicide		Jessup, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the buil	Medical	one) 2 Medical Examiner: On the basis of examination a	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a		
<u>}</u>	ĕ	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)
		Theolog U. V. To	O.C.M.E. 00	June 26, 2009	
d		Name and address of person who complete thuse of death (Item		. UP avec:	
N V		Theodore M. King, Jr., MD. Assistant Medical I		e, MD 21201 	
S Regis		31. Date filed (Month, Day, Year)  32. Registrar's Signat	ball		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0137 AM JUNE Kaymond 2009 COAKIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UMMC Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 21, 9. Birthplace (State or Foreign Country) with 5. Social Security Numbetin Is 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 219-64-7784 64 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director MD Baltimore Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21223 USA Funeral 424 Bentalou Street items 23a 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White ō 1 ☐ Yes 2 🖾 No ģ 3 ☐ Widowed 4XX ivorced 'natural', Completed 16a. Decedent's Usual Occupation UTT (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Delivery Person Pharmacy Department of Health and Mental Hygie Important; If Item 27 is marked other tany Injury or other traumatic event, In once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Mary Weaver 2 James Conklin 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Jin Code)
4005 Bentalou Street Baltimore, MD 21223
22 3. Greene St. Baltimore, Maryland 21201 <sup>19a.</sup> Informant's Name/Relationship *(Type. Print)* Jerome Phillips/brother <del>Jniversity of Maryland Medica</del>l <del>University</del> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signa re of Funeral Savio: Lice e. e. Ronal 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate out e (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Physician /Medical Due to (or as a consequence of): Examiner Hyper tevision
Due to (or as a consequence of): years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform performed? 1 ☐ Yes 2 No 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er deal To the Funeral Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier June 21,2009

State Registrar St. BaltmoriMD 2120

30. Name and address of pers on who con pleted cause of death (Item 23a) (Type, Print)

JUNES

tlob

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
----------------------------------------------	-------------------------------

		For	State of	Maryland /					ental Hy	giene		
		State     Registrar			Cer	tificate	of Deat	th		Reg. No.	nna	20805
Physicia	an	Decedent's Name (First, Middle,	Last)						2. Date of De Month	Day	Year	3. Time of Death
/Medic	_	Leo Joseph Cun							June 19		ty of Death	9:30 AM M
Examin	er	4a. Facility Name (If not institution,		er)			wn, or Locatio				ty of Death 1timo	ro
		Genesis Bright  5. Social Security Number 6		. Age (In yrs. last	hirthday)	Lu If Under 1	thervi:	LLE der 24 Hrs.	8. Date of Birt	th		place (State or Foreign
Funeral Director		212-12-4132	1 M 2 □ F	87	Yrs.		Days Hour	s Min.	(Month, Da	y, Yea <i>r)</i> 2 <b>,</b> 1921	Coul	vland
		Usual Residence of Decedent										
how at		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limits
e Ma ka-f s tiffied	cto	MD Balti	more	Pa	rkvi	11e						1 □Yes 2√∑No
or 28	Pire	10e. Street and Number				10f. Zip C				10g. Citizen o		ntry?
ath w	Funeral Director	8509 B Dempste			10.		21234	0::-0:/0	-76 - V N	USA	ace - Ameri	can Indian
er de items	ı,	11. Marital Status  1 □ Never Married  2 □ Married	12. Was Decede Armed Force d 14 Yes 2	es?	13. V	vas Deceder f Yes, specify	Cuban, Mexi	ican, Puerto	ecify Yes or No Rican, etc.)	Ві	ack, White,	etc.
rs aft I", or xami	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	110 1	6 1	☐Yes 2X	No Spec	cify:		Spec	ity: whi	te
2 hou atura cal E	P E	15. Decedent's	Education	1		lent's Usual (			unk	16b. Kind of	Business/Ir	ndustry
thin 7 e. an "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed)  College (1-4	lor 5+)	life. L	OO NOT use	done during n retired)	HOSE OF WORK	rig			
ed will	S	12	0							steel	_	try
be fill d oth even	Be	17. Father's Name (First, Middle, La							(First, Middle,		ame)	
i Men i Men arke	မ	Raymond A. Cunr		Т.					ne Murr		Ot- t- 7:	- C- 4-)
12 sh h and 7 is n traun		19a. Informant's Name/Relationship Bonnie Fowler/d		1					a <i>l Route Numb</i> nore, M			p Code)
1 and Healt tem 2	}	20a. Method of Disposition		20b. Place	e of Dispo	sition (Name	of		Date	20c. Location	n - City or T	own, State
ages ent of rt: If it		1 ☐ Bunal 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		ate	etery, cren	natorý or oth	er place)					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li Ronald S			22	. Name and	Address of Fa	acility	1 (55			
Dep lmp any			/ / // //	10111				•			timore	e Street
		25a. Part1. Enter the disease, or p shock, or heart failure. List or	omplications that cau	used the death. [	Do not ent	er the mode	of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Comi	dication	sns	of m	etast	atic	Prosto	He Cav	ncer	Onset and Death
/Medical		resulting in death)	Due to (or	r as a consequen	ce of):		00,000			_		
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ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequen	ce or):							
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cate be executed obysician and the burial-transit	dical E		4									
ifficate g phy as the	edic		u									
leath certific attending p I for use as	M/m	IF FEMALE: 23b. Was decedent pregnant		ome pf pregnancy th 2 ☐ Fetal de		Ectopic pred	nancy				Date of deliv	
e deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of deatl		Other (spec					Month	Day Year
at the l by th	Physician/Me	9 Unknown							00 - Did			the cause of death?
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant condition  Demention	s contributing to dea	ith but not resultin	ig in the ui	nderlying cau	ise given in Fa	art I,		Yes 2□ No		
requi	Completed by	PCINCINIO										
<b>sician;</b> The law scertificate has t irector, page 2 s	ld m								24a. Was auto			topsy findings available ompletion of cause of
n; Th ficate r, pag		05 14/							1□ Yes	2 🗹 No	1 ☐ Yes	2 No
sicial certii irecto	) Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Ing	notiont 2 TER	/Outpatier	nt 3∏ DOA	Othor	7	h (Check only		Other (Cnee	
Physer this	-: To	27. Manper of Death	28a. Date of	Injury 28	Bb. Time of		c. Injury at Work?	Nursing Ho	me 5 Res			iry)
nding th.	tior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		, Day Year)	Injury	M	Work? 1 ☐ Yes 2	2 □ No				
Atte	ifice	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	Zoe. Place u	of injury - At home g, etc. (Specify)	, farm, str	eet, factory,	office			Street and Nu wn, State)	mber or Ru	ral Route Number,
talor rs afte al Dir	Certification:			g, (-p)								
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	edical		Physician: To the be xaminer: On the bas and manne	sis of examination								
To the To the To the Somple	Me	29b. Signature and title of certifier	,			29c.	License numb	per		29d. Date sig	ned (Month	n, Day, Year)
							D617	731		6-1	9-2	009
		30. Name and address of person w	no completed cause	of death (Item 23	Ba) (Type,	Print)					211	7 0//
		REAN-CARD	EN, 6701	N. C.	hari	es 5	t., Bo	altin	nore,	MD	212	204
Sta Registr		31. Date filed (Month, Day, Year)	32: Re	gistrar's Signature	Lak	2)			/			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17, 20a-c, 22 per fh g893 7-1-09vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (a **Physician** 30 PM 2009 SROFGE /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ical Mercy med If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** M 2□ F Months Days Hours Min. 62 240-74-1430 May 11, Director 1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner ment be reallised at once. 1 ☐ Yes 2√☐ No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1745 Brookview Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: ģ Specify: black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) driver sanitation dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chambers James Chambers Sr. Emma Coleman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sanja Chambers/spouse 1745 Brookview Road Dundalk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 3 🗆 Removal from State state Metro Crematory Inc rematory Inc : 7-1-09 | Baltimore, Md.
22. Name and Address of Facility March, F/H, West 4300 Wabash Ave. Signature of Euneral Service Ronald Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Down Iland disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tsoiration Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and dedetached for use as the burial-transit law requires that the death certificate be executed inc Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ≥ rerai urrector: After this certificate has been s filled in by the funeral director, page 2 should l 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOOL 7708 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Va

State

Registrar

31. Date filed (Month, Day, Year)

JUN 30

2. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year Month **Physician** Stephen Blane Cromwell 24 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Essex 73 Ginwood Lane 8. Date of Birth NOV • 15, 1954 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD Days Hours Min. 213-68-7573 1 □ M 2 □ F Months MD 54 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Essex MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21221 73 Ginwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Yes 2 f Yes, Give 1 Never Married 2 Married 1 ∐Yes 2 🔣 No Specify. White þ Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Carpenter 11th permit. Pages 1 and 2 should be filled. Department of Health and Mental Himportant: If them 27 is mediany in other any Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion E. Donahue Carl H. Cromwell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 73 Ginwood Lane Baltimore MD 21221 Linda Cromwell /wife 20b. Place of Disposition (Name of Date Date Date BayView Crematory (1997) Baltimore MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final etastanc Curcinsma month disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of 24a. Was ar autopsy performe death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

burial-tran Box 68760, attending physician for use as the burial P.O. the detached sate has been signed by page 2 should be detact Division of Vital Records, certificate Physician: director, After this funeral To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Examiner must be notified at

2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite

Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

with the Maryland Show

death

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Pay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bak

Philadelphia Rd Suite208 32. Registrar's Signature

State Registrar

Medical

31. Date file (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE GLENDON AVENUE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sev **Funeral** 1 X M 2 □ F Months Days 237-42-267 AUGUST 19,1930 N. CAROLINA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show ? is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner rust be notified at 1 Yes 2 No Director 13ALTIMORE MARYLAND 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 21223 SA 1338 GIENIDONI Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HUSPITAL MAINTENANCE 9TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be DON DOGGETT ပ UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trainonce. 1338 GLENDONI AVE., BALTIMORE, MD 21223 ELIZABETH DOCGETT (WIFE) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY 06/13/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

SOSEPH H. BROWN JR. FUNERAL HOME

SU40 N. FUTUN AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovasculards ase PROBABLE **Physician** Syears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (ur as a curisequence uf). that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a o 9 Unknown 9 Unknown signed by t ۵. 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 □ Yes 2 🗷 No 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours a er dearh To the Funeral Director filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

JUN 3 0 2009

Nancy

31. Date filed (Month, Day, Year)

Waxman

30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature Sever S. Janes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician TUNE 200 : 45 pM /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not inch titution, give street and number Examiner Halth + Kehab Himole mmi HOP If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Sept. 20 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Months 212-52-4806 1 □ M 2 🖫 🗗 Yrs. Vivainia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Worldon Exaction in the town the 1 DYes 2 □ No Director toward 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. lac Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than re-tan 0 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) Be auahar ٩ 19b. Mailing Address (Street and Number or Rural Route Number, or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) nt of Health a If item 27 is or other tra MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State Kaltimore Meadowridge L'emeten 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lieenses tonu tord 20794 10220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 57 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ X o 24a. Was an autopsy 2 100 Vital 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of After this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 00061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O WILKENS AVE #307 BALT, Mus 21225

State Registrar

31. Date filed (Month, Day, Year)

22. Registrar's Signatur

QUAINDOWN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Maryland / Department  State of Maryland / Department  Certificate			)	009 20810
			1. Decedent's Name (First, Middle, Last)	OI Dealii	2. Date of De	nog. no.	3. Time of Death
	sicia	n	CATHERINE HUMPHREY DUBOIS		JUNE 2	Day	9:45 A M
	edica mine			own, or Location of Death	OOML 2	4c. County	
			GLEN MEADOWS RETIREMENT GLEN	ARM		BALT	IMORE
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Vith V		Ž	29b. Signature and title of certifier	License number		29d. Date sign	ied (Month, Day, Year)
			· /wixiwy	J30435		JUNE of	.6, 2009
			30. Name and address of person who completed dause of death (Item 23a) (Type, Print)	es for Bal	limoe	, Md	1 21204
Reg	Stat jistra		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUN 3 0 2009				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per State 68 Mar 66 10/09 eput tment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 **Physician** 7:00 PM M Wilma K. Darnell June 18, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr 9, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 💢 F Missouri 83 498-20-4234 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2√☐ No **Funeral Director** MD Chevy Chase MOntgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 USA 4716 Bradley Blvd #302 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 □ Divorced unic Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, he hydron" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ġ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arminta Messenger Louis Alfred King ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 804 Country Club Drive Modesto, CA 95356 Sharon Titus/daughter Health em 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rola S. W. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, or complications that caused the shock, or heart failure/ List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ischemia and infarction two weeks bowe1 /Medical Due to (or as a consequence of): Examiner peripheral vascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of). attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. this certificate has been signed by the all director, page 2 should be detached 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ malnutrition 2 🔲 No 3 ☐ Probably 4 ☐ Unknown Completed anasarca 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 21√Mő 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 18, 2009 D 67986 30. Nax and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DARNELL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Month **Physician** June 18, 3:03 AM M Charlene M. Drury /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil E1kton Union Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov 16, Nov 16, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1□M 2√F 1935 73 Director 205-28-8369 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination of the result of the property. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√☐ No Director MD Cecil E1kton 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 150 E. Main Street #310 21921 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian, 11. Marital Status Black White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) unk College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Robinson William Paul Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elkton, MD 106 Bow Street 21921 Union Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 □ Other (Specify) 21. Signature of program of social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control of the social control o . Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) Myrocardia **Physician** warehow /Medical Due to (or as a consequence of): Examiner Art CORCURAY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical certificate has been signed by the attending prector, page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 □Yes & No ours after death.

eral Director: After this certific.
filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 25 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a Funeral I Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical within 24 hor To the Fune completely fi the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela DYE. (earl Le Claire North East 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 06 Edwin L. Doering 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Square Franklin HUSDITA 8. Date of Birth (Month, Day, Year) 8 – 20 – 1934 Birthplace (State or Foreign Country) ge (In yrs. last birthday) 5. Social Security Number Days Min. 1 🛛 M 2 🗆 F Months Hours 74 MD 215-30-0675 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21220 410 Wagner Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 Xes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 1 ☐ Yes 2 TVNo Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aluminum Siding Installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Inez Doering Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21220 Erica Mitchem - Daughter 410 Wagner Lane, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 6-30-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bradley-Ashton Funeral Home 21222 Willow Spring Road, PA, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tis (Pseudomembranous Severe Acute disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) Hospital:

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760, signed by the ar been si should b s certificate has be irector, page 2 sl director,

**Physician** 

/Medical

Examiner

Funeral

Director

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ral", or items 23a or 28a-f shore Examiner must be notified at

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permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.

**Physician** 

Examiner

/Medical

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Funeral

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with the Maryland

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) ature and title of certifier 29c. License number 29b. Sigr

who completed cause of death (Item 23a) (Type, B Name and address of perac

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State Registrar 31. Date filed (Month, Day, Year)

		_ FOr	partment of Health and Mertificate of Death	-	ne						
Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) ANN MARIE DIETRICH 4a. Facility Name (If not institution, give street and number) Berlin Nursing Home		2. Date of Death Month  June 26	Day Year 3. Fine of Death 4:40 A M 4:40 A Worcester						
Funeral Director		5. Social Security Number 215-09-7252  Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth Month, Day, Yea UIY 23, 19	9. Birthplace (State or Foreign						
th the Maryland or 28a-f show a notified at	irector	10a. State 10b. County 10c. City, Town or	k Island 10f. Zip Code	10g. (	10d. Inside City Limits 1 ☐ Yes 2 ☐ No Citizen of What Country?						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 MNo	19975 3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto language 1 □ Yes	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White						
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VICI YICILU KIKI 12 should be filed within h and Mental Hygiene. 7 is marked other than traumatic event, the Me	To Be Co	17. Father's Name ( <i>First, Middle, Last</i> )  John Amberg			en Surname)						
Pages 1 and 2 si ment of Health an ant: If item 27 is uny or other traus		Marjorie Joan Rekus DTR 304  20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition	Lothian Way Abingdo  position (Name of rematory or other place)	n, Maryla	nd 21009 Location - City or Town, State						
permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee  Annis Destan EMARIS	Timonium, Maryland feld Funeral Home In re, Maryland 21212								
Physician /Medical Examiner		23a. Part1. Enter the displayer, or convocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ASCVD  Due to (or as a consequence of):									
The law requires that the death certificate be executed are has teen signed by the attending physician and ragge 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libease of militry that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c									
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tal net	Be Completed	25. Was case referred to medical examiner?	26. Place of Death		No 1 □Yes 2 □ No						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, gage 2 should be detached for use as the	Certification: To I	1   Yes   Yes   No   Hospital: 1   Inpatient   2   ER/Outpat   27. Manner of Death   28a. Date of Injury   28b. Time   Injure   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   Hospital: 1   Inpatient   2   ER/Outpat   28a. Date of Injury   28b. Time   Injure   28e. Place of Injury - At home, farm, building, etc. (Specify)	28c. Injury at Work?  M 1 Yes 2 No	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number City or Town, State)							
he Hospital on 24 hours at he Funeral Coletely filled i	edical Cer	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.									
To th withi To th	M	29b. Signature and title of certifier  30. Name and difference of death (Item 23a) (Type	29c. License number  D 43195.	6	Date signed (Month, Day, Year)						
Sta	ate	30. Name and address of person who completed cause of death (Item 23a) (Typy OGESH VOHRA 614 ENSTERN SH 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ORE OF, SALISBUA	Ly, MO, 218	304,						
Regist	rar	JUN 3 0 2009 Denor 7. 7									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** June 24, 2009 5:55 A. Cecilia В. Dinnell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Harford Gardens Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August 20, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Mary Tand 216-12-9748 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count 28a-f show other traumatic event, the Medical Examiner must be nuttined at N/A Baltimore Maryland **Funeral Director** 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 4505 Simms Avenue 21206 or items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White þ Specify: 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Stationary 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Stanley Reisler Helen Johnson ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Weaver Avenue Baltimore Maryland 21214 Christine McGrath/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6/27/09 Parkwood Cemetery Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Faciliting 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENTIA **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place O'Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signa (re and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number completed cause of death (Item 23a) (Type, Print) Walksun Woods Roll, mp 21234 31. Date filed (Month, Day, Year) State JUN 30 Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For Stete Registrar	State of Maryland	d / Department of Health and N	Mental Hygiene	
	Physici /Medi	cal	Decedent's Name (First, Middle, Last     Dawn     Oc     4a. Facility Name (If not institution, give	tavia D	ent 4b. City, Town, or Location of Death	2. Date of Death Month Day	3. Time of Death
	Examir Funeral Director	ner	Union Memo 5. Social Security Number 6. Se	rial Hosp	ital Baltimore	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)  Naryland
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Marical Examinational Examinational angue.	by Funeral Director	10e. Street and Number  170	Place Apt.  12. Was Decedent Ever in U.S. Armed Forces?  1   Yes 2 No If Yes, Give	10f. Zip Code  2 2 7  3. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
21215-0036	J within 72 hours jiene. r then "neturel" Ire Madical Ex	Completed b	15. Decedent's Edu (Specify only highest grad	Year or Dates:  cation e completed)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b. Ki	nd of Business/Industry
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Robert Ric	hardson		e (First, Middle, Maiden	Surname)
	Pages 1 and 2 sho nent of Health and I int: If item 27 Is ma iry or other treums		19a. Informant's Name/Relationship (7)	20b. Planoval from State	19b. Mailing Address (Street and Number or Run ace of Disposition (Name of metery, crematory or other place)	Ud. 312	ocation - City or Town, State
Baltimore,	permit. Pa Departmen Importent: any injury once.		4 □ Donation / 5 □ Other (Specify)  21. Signature of Funeral Service Licens	IGIT	en Mount (remotity of 22. Name and Address of Facility of Seph L. Russ F	uneral t	Home PA.
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68760, 4	Medical Examine physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of).		
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rds, P.	quires that I n signed by uld be deta	d by Ph		ntributing to death but not result	Iting in the underlying cause given in Part I.		use contribute to the cause of death?
al Records,	n: The law red icate has bee r, page 2 shou			order		24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
	ing Physicien: . After this certifica uneral director, i	ion; To Be	27. Manner of Death  1 Natural 5 Pending	lospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	PR/Outpatient 3 DOA Other: 4 Nursing House Injury at Work?	th (Check only one) ome 5 Residence 28d. Describe how injure	
Division	of or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	(Check only 2 / Medicel Exemi	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occur	red at the time, date and	1 place, and due to the cause(s)
	To T COM	2	29b. Signature and title of certifier	),MD	29c. License number  DCO 5545	9 9 Da	te signed (Month, Day, Year)  12 2009
-ric	\		30. Name and address of person who co	mpleted cause of death (Item  32. Registrer's Signatu	n Werb, Union	Memori	al Hospital
	Sta Registr		JUN 3 0 2009	Descript B. 1	base		

Edward.	ark Davis	
09-04998	Please Type or Print in Black Indelible Ink. Ensure All Co	III .
UNK UNK	State of Maryland / Department of Health and Mental  For State  Certificate of Death	2003 2001
Physicia	egistrar  Decedent's Name (First, Middle,Last)	Reg. No.  2. Date of Death  3. Time of Death
Medical Examin	Edward Mark Davis	June 24, 2009 Year 1825 hrs
	la. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D	
	1826 St. Paul Street Baltimore	N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (MM/DD/YYYY) 9 / Birthplace (State or Foreign Country)
	213-96-7903 1⊠M 2□F 39 Yrs. Sual Residence of Decedent	Aug. 7, 1969 Maryland
any	0a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
*	Md. NA Baltimore	1 XYes 2 No
the Maryland a or 28a-f show tiffed at once.	0e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
h the ?	1826 St. Paul Street   21218	USA
r death with th or items 23a	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 14. Was Decedent of Hispanic Origin? 15. Married Porces? 16. Yes, specify Cuban, Mexican, Pu	
rer des	1 Yes 2 No No Specify:	specify: RIAK
urs aft tural"	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind	of work done 16b. Kind of Business/Industry
5 72 ho	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	e retired)
5-0036 ed within 72 hour tygiene. other than "natu	12 0 Unemploye	d NA
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland nt of Fleatth and Mental Hygiene. It: If Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	17. Father's Name (First, Middle, Last)	lame (First, Middle, Maiden Surname)
212 212 Ment Ment mark	9a. Informant's Name/Relationship (Type, Print ) Brother 19b. Mailing Address (Street and Number	r or Rural Route Number, City or Town, State, Zip Code)
MD 12 sho th and 1.27 is umati	Mr. Malcolm Davis 5229 St. Char	les Ave. Balto. Md. 21215
ore, MC es I and 2 s of Health at If item 27	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Pages nent of lant: If or other	4 Donation 5 Other Specify: Mt, Carmel	12/2009 Dundalk, Md.
Baltimore, MD pernit. Pages I and 2 she Department of Health and Important: If Hem 27 is injury or other traumati	21 Signature of Funeral Service Liceasee 22. Name and Address of Facility JOSE Ph L. R. J.S.S.	Funeral Home, P.A.
Physician	22.72 W. Nor H.	iac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line.	Between Onset and Death
xaminer	mmediate Cause (Final disease or condition resulting in death)  a. MUITIPIE INJURIES  Due to (or as a consequence of):	
	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):	
11) Kg ig	f any, leading to immediate Due to (or as a consequence of):  Touse Fine Underlying Cause  Disease or injury that initiated  C.	
My cuted and transit	events resulting in death) Last Due to (or as a consequence of):	
al - tran	d. UNPENDED AMENDED	
ox 68760, stantificate be executant attending physician and or or or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use as the burial - trick or use a	F FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
68760, certificate be nding physici use as the buri	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pr	egnancy Month Day Year
Box 68760 e death certificate b the attending physical for use as the bu	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)	
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
, P.O. ires that the signed by		1 Yes 2 No 3 Probably 4 Unknown
Records, The law require rate has been signage 2 should b		24a. Was an autopsy findings available prior to completion of cause of
Rec(The lar		performed?   death?   1 🗸 Yes 2 No 1 🗸 Yes 2 No
tal R cian: 1 certific ector, p	5. Was case referred to medical examiner?   Garage   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Control   Con	neck only one)
f Vit	1 V Yes 2 No   No   No   No   No   No   No   No	iursing Home 5 Residence 6 Other: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	27. Manner of Death  28a. Date of Injury  1 Natural 5 Pending  28a. Date of Injury  FOUND:  28b. Time of Injury  28c. Injury at Work?  FOUND:  1 Yes 2 ✓ №	28d. Describe how injury occurred Subject assaulted
Division o ital or Attending ars after death. ral Director: Aft	2 Accident Investigation Jun 24, 2009 1810 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Div ital or ral Di	Suicide 6 Could not be determined (Specify) Multi-Family Apt.	or Town, State) 1826 St. paul street, Baltimore, MD
hor hor	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cause(s) and manner as stated.
To the He within 24 To the Fu Complete)	2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occur and manner stated.	
	29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	Call O.C.M.E.	June 25, 2009
2	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, ME</li> </ol>	21201
Sta	31. Date filed (Month, Day, Year) 32. Registrary Signature	
Registr	JUN 3 0 2009 /	

State Registrar O.C.M.E

111 Penn Street, Baltimore, MD 21201

June 20, 2009

Assistant Medical Examiner

32. Registrar's Stanature

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna M. Vincenti, MD

31. Date filed (Month, Day Year)

	-	For State Registrar	State of Ma	ryland		artment <i>rtificate</i>			and Me		giene Reg. No	-211	09	20819
Physicia: /Medica		1. Decedent's Name (First, Middle, Last)  Ida Emily Eybs								2. Date of Dea Month	Da		Year	3. Time of Death
Examine		4a. Facility Name (If not institution, give s Carroll County Ge	,			4b. City, To Wes		ocation o		700,110, 2		. County	of Death roll	
Funeral Director		215-01-2080	1	(In yrs. la	ast birthday) Yrs.	If Under 1 Months 0		f Under 2 Hours	Min.	B. Date of Birt (Month, Da March				place <i>(State or Foreign</i> intry) 'yland
f show		Usual Residence of Decedent  10a. State 10b. County  Md. Balti	more	10c. City	Town or Lo	cation arney								10d. Inside City Limits 1 □Yes 2∑No
23a or 28a-f show	al Director	10e. Street and Number 10f. Zip Code 2418 Lakewood Road 21234							10g. Ci	tizen of V	What Cou	-		
al", or items	Dy Fu		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ∑ N If Yes, Give Year or Dates:		F	Was Deceder fYes, specify		panic Orio Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	-		ck, White,	ican Indian, etc. White
Department or realin and wential ryyletre. Important: If item 27 is marked other than "natural", any injury or other traumatic event, If a Madical Evo	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+	+)	(Give life. I	dent's Usual ( kind of work OO NOT use okkeep	done dur retired)	ne during most of working red)				16b. Kind of Business/Industry		
Aental Hyg	lo Be C	17. Father's Name (First, Middle, Last) Charles Mayer							r's Name (First, Middle, Maiden Surnan Line Schultz			me)		
alth and N	-	19a. Informant's Name/Relationship ( $Ty_1$ ) John R. Eybs	oe. Print)	n		ng Address (S				Route Numbe				
nent of He ant: If item ury or oth		20a. Method of Disposition  ¶☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Pl	ace of Dispo emetery, cren l Air	sition <i>(Nam</i> e natory or othe Memori	of er place) a1	6	Da 5-27-				City or T Md	own, State
Departi Importi any inji once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Schimunek Funeral 1  9705 Belair Rd. Nottingham, Md. 21												
nysician Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause of each line.  Due to (or as a	15	on P	ner the mode			cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	Due to (or as a										,	
- O)	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) □ 9 □ Unknown											te of deli	very Day Year
be d	6	Part II. Other significant conditions cor	tributing to death bu	t not resu	Iting in the u	nderlying cau	se given	in Part I.				use cont		the cause of death?
page 2	Completed								24a. Was autor perfo 1 □Yes	autopsy prior to completion of cause of death?				
	10 De	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	ospital: 1 Inpatier	v	ER/Outpatier	nt 3 DOA	Other:	4 □ Nu	rsing Hom	(Check only one 5 ☐ Resi	dence			cify)
within 24 hours after death.  To the Funeral Director: After thi  completely filled in by the funeral I	Certification: 10	1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, 28e. Place of Inju- building, etc.	(Year)	Injury me, farm, str	Work? M 1 □Yes 2 □ No			(Street and Number or Rural Route Number,					
Funer etely fil	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and magner state	examinat	wledge, deat ion and/or in	h occurred at vestigation, i	the time	, date an nion, dea	nd place, a oth occurre	and due to the	cause( date ar	s) and m	anner as and due	s stated. to the cause(s)
To the Fun Completely	Me	29b. Signature and title of certifier	M M	0		29c. I	License r	number			29d. D	ate signe	ed (Month	1, Day, Year)
		30. Name and address of person who co	show	11	23a) (Type,	Print)	r( (	ent	4	)nhe	2	Pist	3/20	1, MD 2/136
State Registra		31. Date filed (Month, Day, Year)	32. Registra	s Signat	are /			,			•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g892 6-30-09 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 28, 2009 Ronald Hayes Elza, Sr. 1:30 A.M June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Co. 618 Mayo Road Glen Burnie 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Director 18, 1949 214-52-8653 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show Exacilities is ust be notified at 1 ☐ Yes 2 No Director Virginia Westmoreland Co. Montross 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States Funeral 331 Horners Mill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces:

1 Yes 2 No
If Yes, Give
Year or Dates: Vietnam 1 Never Married 2 Married Maryland 21215-0036 6 1 □Yes 2√□No Specify: White Completed by 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Marine Corps Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be filt tment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even Be Julius Hayes Elza, Jr. Marion S. Harris ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr Mrs. Shannon E. Burgess/Daughter 1402 Piney Grove Rd. Warsaw, VA Saltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | July 3, 2009 Glen Burnie, MD 21. Signature of Funeral Se 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Saqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2/2No 1 ☐Yes 2 ☐NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home State Nother (Specify) S1Ster Nouse sister's 1 Yes 2 No this Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Division 1 Natural 5 ☐ Pending investigation death. ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 3/322 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD, PASAD GNA, MY21/2L PRADEEL MOUNTAIN GARG 4304

State Registrar 31. Date filed (Mo

1 - For State Registrar

**Funeral Director** 

To Be Completed by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

State Registrar			-		•	ificate				/lental		. No. 2	nr	J G	21	182
Decedent's Name	e (First, Middle,	, Last)								2. Date of	of Death	Day	V 4	ear	3. Time	of Death
Jacob	Epstein	1										Day 200		-ul	3:50	O PM M
Facility Name (II	If not institution,	, give street and nu	(mber)		4	4b. City, To	Town, or	Location	of Death			4c. Cour	-	Death		
	est Hos							stown		T		В		imo		
5. Social Security Number 6. Sex 7. Age (In yrs. last birthda					N	If Under 1 Months	1 Year Days	If Under Hours	r 24 Hrs. Min.		th, Day, Y	'ear)	9.	. Birthpl Count	lace (State	e or Foreigi
026-18		1 <b>∑</b> M 2□F	9	3 Yrs	10.					Dec		1915	1		ginia	t
al Residence of State	f Decedent 10b. County		100	c. City, Town o	or Locat	tion			,					10	0d. Inside	City Limits
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Marital Status	unk	IZ. Was Dec	edent Ever	in U.S.	13. Wa	as Decede	ent of His	spanic Or	rigin? (Sp	pecify Yes o	or No-				an Indian,	
Marital Status  1 □ Never Marri	ied 2□ Marrie	Armed Fo	orces? 2 ☐ No							o rican, etc	U.)			White, e		
3 ☐ Widowed		If Yes, Gi Year or D	ive	43-45	1[	□Yes 2	. No Lo⊔ Lo⊔	Specify.	e			Spe	ecity:	wh	ite	
/Cnn-	15. Decedent	t's Education st grade completed)	)	16a. D	eceder	nt's Usuai ind of work	Occupa	ation	st of worl	rina	16	6b. Kind of	f Busin	ness/Inc	dustry	
Elementary/Seco	ondary (0-12)	College (	(1-4or 5+)	1		ind of work O NOT use				ø			1			
12		5+			pro	ofess				- /	14.5		leg			
Father's Name		Last)								ne <i>(Fir</i> st, <i>Mi</i> e Fish		aiden Suri	name)			
aron Ep				1		A						311				
a. Informant's Na orthwes		hip <i>(Typ</i> e. <i>Print)</i> Ltal								ral Route A Randal					Code) 133	
				1						Date						
	☐ Cremation	3 Removal from		0b. Place of D , cemetery,	: crema	tory or oti	her place	2)		Date	20	Dc. Locatio	эн - Cit	y or To	wii, State	
4 <b>∑</b> Donation	5El Other (Sp		V					1								
. Signature of Eu	-		11		_	h1-			1124							
R	onald (	Licensee Wade,	Pirec	E9r			d Addres	ss of Facil		ard 65	55 W	. BaJ	Ltin	nore	Str	eet
12/2	22/	icensee Wade,	Luc		В	Balti	d Addres Ana Lmore	ss of Facilia to my	21	1201			 tin	nore		
a. Part1. Enter the shock, of hea	the disease, or art failure. List of		caused the		В	Balti	d Addres Ana Lmore	ss of Facilia to my	21	1201				nore	Approxim	nate Between
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within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician /Medical Examiner

Physician/Medical Examiner

d by	Advanced	1 Yes 2 No 3 Probably 4 Unknown						
Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes → No			
a	25. Was case referred to medical		26. Place of Death (	Check only one)				
To B	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	OA Other: 4 Nursing Home	e 5 ☐ Residence 6 🔀	Other (Specify) ASS Hed Livin			
	27. Manner of Death	28a. Date of Injury 28b. Time of 2	28c. Injury at 28 Work?	d. Describe how injury o	ccurred			
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Ö		nome	ikesuille.	Maryland 21209				
Medical (		nysician: To the best of my knowledge, death occurred miner: On the basis of examination and/or investigation and manner stated.						
ž	29b. Signature and title of certifier	290	c. License number	29d. Date s	igned (Month, Day, Year)			
(	I to the the	MD Deputy I	)18667	June	22,2009			
	30. Name and address of person who	completed cause of death (Nem 23a) (Type, Print)	Hill CT. Lutl					
ite	31. Date filed (Month Day, Year)	al of D total of at an a						
ar	JUN 3 0 2009	Denous B. Market						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician**  $P^{M}$ 19 2009 1643 June Harold Eccles-James /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Hours Min. 1 X M 2 □ F 60 November 4, 1948 Sierra Leone Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 Sierra Leone 546 Monet Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify: Black þ 3 ☐ Widowed 4 反 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Boxing/Sports 12 Boxer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Princess Arina Thomas Horace Ekudayor Eccles-James ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6954 N. Sheridan Road, #308, Chicago, IL 60626 Charles Eccles-James/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 30, 2009 Department of Important: If It any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 any uttr M01548 23a. Part1. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner death certificate be executed physician and s the burial-trans Liver Failure Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day ρ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed by the period of the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the details and the de 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗌 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD uadav D67512 June 19, 2009

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

9901 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Madan Sampath Bangalore, M.D.

31. Date filed (Month, Day, Year)-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month **Physician** 10:31AM 2009 June lana /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Yea June 18, Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Year) 1 X M 2 - F 52 213-68-9319 Tune Maryland Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 28a-f shov 1 Yes 2 No Churchton notified Director Md. Anne Arundel 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a or ö MIT 5708 North Shore Parkway 20733 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 XNo Specify Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 years Waiter Resturant years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic ever Harry English Carol Hadley ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5708 North Shore Parkway, Churchton, MD. 20733 Health a Carol English Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State June 26, = 50 Department of Important: If any injury or once. Bayview Cremotory Baltimore City, Md. 4 Donation 5 Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, e, o complications that caused the death. List only one cause on each line. Approximate Interval Between 23a. Part 1. Enter the disease, shock, or heart failure. Li not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Metastatic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 □ Probably 4 □ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗌 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Tes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 No 2 Accident Director: A Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Box 68760, Division of Vital Records, P.O.

DHMH 17 Rev 1/2001

the Funeral Directory filled in Hospital

within 2 To the

Medical

State Registrar

29a. Certifier (check only

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30. Name

29b. Signature and

31. Date filed (Month

title of certified

Q

ddress of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number Res-000

600 North Wolfe St, Baltimore, MD, 21287

STEVE Ford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day June 24, 2009 1154 hrs STEV12 Medical Examiner FORD 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Min Months Days 9/21/19 Director Country) MARYLAND 217-25-7161 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No BALTIMORE Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene.
tant: If itien 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country 10e. Street and Number U.S.A. 21216 4503 BONNER 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Yes Specify: BLACK Yes 2 No specify: Widowed Divorced If Yes. Give Year \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 IOTH GRADE UNEMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MACK Be TR G. FORT (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt.) BAITIMORE, MD 21216 BOUNTER RD., AFT. B 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, ltimore, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BHITIMORE, IMARYLAND Donation 5 Other Specify: JR. FUNIERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JOSEPH H. BROWN 2140 NI. FULTON AVE, BALTIMORE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wound of Neck Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify) Unknown Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Jun 24, 2009 Subject shot 2320 hrs Natural Yes 2 V No Pending filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 313 Mason Court , Baltimore, MD determined (Specify) Multi-Family Apt. To the Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number June 25, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 09-04969 Edward Faulkner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

awara r adikire		1- For State Registrar Certificate of Registrar		• •	2009 g. No.	3 20825
Physici		1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exami	iner	Lawa a launte	o. City, Town, or Location of Deatl	June 23, 20	009 4c. County of Death	2218 hrs
		913 Bradford Street	Baltimore	'	MA	'
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24Hrs Months   Days   Hours   Mir	_	n(MM/DD/YYYY) 9. Bir Foreig	
Director		217-34-27/2 1×M 2 F 70 Yrs.	Months Days Hours Mir	Julys	22,1938 00	untry) Virginia
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n		1	10d. Inside City Limits
A	'n	Md. N/A Baltir	nore			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
ith the 1 23a or notifie	al Di	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	2/205		USF	- Latin Black
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Ye	Decedent of Hispanic Origin? (Ss, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,
after d al", or	by Fu		Yes 2 No specify:		Specify: B	ack_
136 hin 72 hours afte e, than "natural",	ted !		s Usual Occupation (Give kind of st of working life. DO NOT use ret		16b. Kind of Business/	ndustry
5-0036 led within 72 hours Hygiene, other than "natus	Completed	College (1-4 of 54)	tor		Carson	Tnn
21215-0036 uld be filed within 7 Mental Hygiene, marked other than		17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, M	alden Surname)	1
21215-C uld be filed v Mental Hygi marked oth	o Be	19a. Informant's Name/Relationship (Type, Print) (19b. Mailing)	Address (Street and Number or	tai	uKner	7in Code)
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re, M 1 and 2 f Health If item 2 er traun		20a. Method of Disposition  20b. Place of Disposit  1 Burial 2 Cremation 3 Removal from State	on (Name of cemetery, er place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other Specify: \[ \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \( \tau \) \(	He VA Cem. 11	1/2009	Crownsv	ille Md.
Baltimore permit. Pages 1 Department of E Important: If i		27. Signature of Funeral Service Licensee 22. Na 30.5	me and Address of Facility	meral	Home, P. A	: 24244
Physician		238 Part 1. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval
/Medical Examiner	1	∬failure. List/only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dise	ase			Between Onset and Death
•		or condition resulting in death)  Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
nt: =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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760, cate be execut physician and	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	,
30x 6876( death certificate e attending physic		23b. Was decedent pregnant in the past 12 months?	I death 3 Ectopic pregna	ancy		Day Year
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other	er (Specify)			
, P.O. Box 687 ires that the death certiful signed by the attending be detached for use as t		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to	
ords, F w requires s been sign should be	Completed by	Diabetes Mellitus		24a. Was a	2 No 3 Prot	topsy findings available
COF Law re has be e 2 sho	mple			autops perform	y prior to o ned? death?	completion of cause of
Il Rec in: The l rtificate b tor, page	യി	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Ye	s 2 No
Division of Vital Records, saler Attending Physician: The law requires at lot after the this certificate has been sale birector, page 2 should led in by the funeral director, page 2 should.	To B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient			Residence 6 🗸 Other	: Scene
n of ding Ph. h, After t		27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	ury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
riSiO r Atten er deat irector	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street		28f. Location (St	reet and Number or Ru	ral Route Number, City
Div Dital or ours aft cral Di	Serti	4 Homicide determined (Specify)		or Town, Sta	ate)	
Division  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: . completely filled in by the fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation				
To the within 2 To the complete	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Moi	
•		and	O.C.M.E.		June 24, 2009	
2		30. Name and address of person who completed cause of death (Item 23a)	1			
	oto		reet, Baltimore, MD 2120	1		
51	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

OCME

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23 are of Maryland 802 posting plot Haalth and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DOROTHY MARIE GRACEY 2009 12:37P M JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 57 Belmore Rd. Lutherville . Social Security Number 214-14-1060 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State Oct. 30, 1920 Mary Land **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 88 Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Marvland Baltimore Lutherville 1 ☐ Yes 2 🔀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21093 USA 57 Belmore Rd. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
em 27 Is marked other than "natural", or Itel other traumatic event, the Moulical Experiments. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: ģ 3 X Widowed 4 ☐ Divorced WW11 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hutzler Co. Salesperson vrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Bigham Cleveland White ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Gracey (Son) 57 Belmore Rd. Lutherville, Maryland 21093 permit. Pages 1 and 3 Department of Health Important; If Item 27 any injury or other tr once. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burià 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 6-22-2009 4 □ Donation 5 □ Other (Specify) Baltimore, Md. 22. Name and Address of Facility
Lassann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Party Enter the disease, or constitute, List only Approximate Interval Between Onset and Death recations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. mmediate Cause (Final Physician ardiac arrest minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Myelodysplastic syndrome ears burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 □ No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 Ño Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 50 🖍 s 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Lome funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 🗆 No l or Attend after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YorkRd, Suite 224, Towson MD 21204 0+1 MD Rwil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 26

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Year 2001 Month **Physician** 8:40A M Cecelia Irene Garland June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care North Point Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 23 1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 □ F 219 44 5672 Baltimore, Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 4201 Valley Vista Court 21102 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 14 Bace - American Indian Black, White, etc 1 Never Married 20X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: ģ Specify: White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Howard Donaldson Loretta Frances DeVaux ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Joseph G Donaldson (Brother) 4201 Valley Vista Court Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney valley Mem. Gdns. July 1 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ightu e of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Sepsi Physician 0551512 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Gracing in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 💆 No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 1 □ Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier marker Whelm D45757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MELTHEN

32. Registrar's Signature

4940

MINESTED

ORIGINAL

Eastern Ave Belt, MD 21224

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	epartment of Health and M Certificate of Death		ene2009	20829
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Luis Garrido Guerra		Month JUN	Day Year	07201AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	- 4(11	4c. County of Death	
*	Examin	er	university of Maryland Medical Center	Baitmire		Baltimore	
	Funeral		5. Social Security Numbelunk 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign
	Director		11XIM 2□ F 70 YI	s. Months Days Hours Min.	Feb 14, 1	1939	and youTik
5			Usual Residence of Decedent				10d. Inside City Limits
relor	show	<u>_</u>	10a. State 10b. County 10c. City, Town of				1 □Yes 2 ☑ No
Ž.	8a-f	Director	MD Prince Georges Laure		10	g. Citizen of What Cou	
with t	De 1		10e. Street and Number	10f. Zip Code 20708	10	USA	andy:
aath ,	is 23	Funeral	3600 Fort Mead Road  11 Marital Status 12. Was Decedent Ever in U.S.		ecify Yes or No-	14. Race - Amer	rican Indian.
ter de	item	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? Unk  1 ▼ Never Married 2 □ Married  1 □ Yes 2 □ No	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Black, White	, etc.
	o","e	þ	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 KgYes 2□No Specify:Mexi	can	Specify: wh	ite
5 5	atura	Completed	15. Decedent's Education 16a. D	Decedent's Usual Occupation unit		6b. Kind of Business/l	ndustry un
<b>7</b> rid	an "n	ed.		Give kind of work done during most of worki ife. DO NOT use retired)	ng		
V 2	/gien er th	ő	Elementary/Secondary (0-12) College (1-4or 5+) unk unk				1-
<b>2</b>	tal Hy	Be (	17. Father's Name (First, Middle, Last) unk	18. Mother's Name	e (First, Middle, Ma	aiden Surname) un	K
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ָם פּיף,	If of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Examination to the traumatic event.	3	1 121	Mailing Address (Street and Number or Run			
בי בי מ	Health			S. Greene Street Ba		Mary Land  Oc. Location - City or	
2 2	or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	crematory or other place)	Jale 2	oc. Location - Oily of	own, Gtato
<u> </u>	rtmer rtant njury		4 □ Donation 5 ₺ Other (Specify) in State	OO Name and Address of Facility		5.5	
ם פון	Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Func. + Squice Licensee, Ronald S. Wade, Virector	State Anatomy Board Baltimore, Maryland	655 W. 1 21201	Baltimore	Street
			23a. Part 1. Enter the disease or complications that caused the death. Do no			st,	Approximate Interval Between
DI	nysician		shock or heart failure. List only one cause on each line.  Immediate Clise (Final	ribiliony concer		7	Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (or as a consequence of				
E	xaminer		Sequentially list conditions b.				
6	=	ner	Sequentially list conditions, if any, leading to time-state cause. Each of the time-state Cause (Disease or Injury that initiated events  c.	y .			
acute	ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C				
b be ex	cian a	<u> </u>	resulting in death) Last Due to (or as a consequence of	):			
Cate	physie the b	dical	d	<u> </u>			
	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of del	harr
ath c	atten for us	ian	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	Day Year
; e	y the	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	3 🗆 Other (specify)			
that	deta		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
w requires t	n sigr	d by			1 ☐ Yes	s 2 No 3 Pr	obably 4 🗷 Unknown
S §	s bee	Completed			24a. Was an		topsy findings available
F election	te ha	шc		-	autopsy	ned? death?	completion of cause of
cian:	tifica tor, p	O	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 h (Check only one		212110
VSici	is cel	To B	examiner? 1 ☐ Yes 2 ☒ No	Other:		nce 6 ☐ Other (Spe	cify)
ם ב	ter th	Ľ	27. Manner of Death 1 № Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) Inj	ne of 28c. Injury at work?	28d. Describe hov	w injury occurred	
SIOII tending	or: An	äţi	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
or Att	fter de jirect in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Str City or Town,	reet and Number or Ri , State)	ural Route Number,
<u>.</u>	eral C		29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place	and due to the ca	ause(s) and manner a	s stated.
e Hos	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.				
Toth	withir <b>To th</b> сотр	Me	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Mont	h, Day, Year)
			Elger Millels-MD	P23046		Jun 21 2	009
7			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)			
			Elizabeth Nichols 22 South Greens	St. Baltmore MD ;	21261		
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 3 0 2009	St. Bathmere MD			
	negisti	वा	JUNDU JUNG APARAM PULL IN 19	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20830 Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ye ar **Physician** JUNE ROBERT 29 6:35 AM GOLDFEIN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY N/A Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1**X** M 2□ F 217-14-0517 86 06/05/1923 Director ٧A Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6317 PARK HEIGHTS AVE., APT. 107 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XiYes 2 □ No WWII If Yes, Give ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 X No WHITE ⋛ Specify: 3 Widowed 4 Divorced "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ TRANSPORTATION ADMINISTRATOR STATE OF MARYLAND marked other 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ges 1 and 2 should be fill to file that the man mental Hall them 27 is marked other or other traumatic ever SAMUEL GOLDFEIN DORA LEVY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH GOLDFEIN / WIFE 6317 PARK HEIGHTS AVE, APT 107, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State B'NAI ISRAEL CONG. 06/29/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Secrice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PNEUMONIA 1 week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner y ears CARDIDIMYDIDA TITY END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PAI WIRE MW M 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 **1**No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2√2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 1 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES 000 29 12009

Registrar DHMH 17 Rev 1/2001

State

AMADEO

31. Date filed (Month, Day, Year)

21215-0036

land

Maryl

Baltimore,

Pages '

The law requires that the death certificate be executed

Division of Vital Records, P.O.

or Attending Physician:

ROBER

GOLDFEIN

park

SINAL HOSPITAL OF

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

82. Registrar's Signature

D. RIVERA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month INE Day **Physician** 09:10AM /Medical 4c. County of Death : more 4b. City, Town, or Location of Death 4a. Facility Name (If no institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funera! Days 1 □ M 2 K F Director arolina 10a. State 10b. County City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lojury or other traumatic event, the Medical Exact in writing to any lojury or other traumatic event, the Medical Exact in writing to any once. 1 ☐ es 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 No if Yes, Giv Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🕍 No 3 Widowed 4 Vivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) anda Father's Name (First, Middle, Be ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru 4 Route Number, City 3/01/6 1 🗆 Burial 3 Bemoval from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use a yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 No Month Year 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I SEPTIC SHOCK 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> No 3 Probably 4 Unknown 1 ☐ Yes director, page 2 should Completed has been ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed?

Ves 2 A No within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

€ V State

31. Date filed (Month, Day, Year)

JUN 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

D37254

MARYLAND

21204

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			1 - For State Registrar			Certificate of			Reg. No. 20	19 20832	
	Physici	an	Decedent's Name (First, Middle, Last)		. (			2. Date of De Month	Day Ye	3. Time of Death	
da.	/Medic		4a. Facility Name (If not institution, give stre	et and number)	HAWKIN		or Location of Death		June 28, 2009 10:53		
7			708 Pennsylvania	Avenu	e Î	Baltimo		NA			
в	Funeral Director		5. Social Security Number 6. Sex 15 M	2 🗆 F	(In yrs. last birtho	Months Days	Hours Min.	(Month, Da		Birthplace (State or Foreign Country)	
	0		Usual Residence of Decedent	b	.3			05-29-	-46	MD	
	Maryla f shov	ē	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 ☑ Yes 2 ☑ No	
	or 28a	Director	MD NA  10e. Street and Number		Baltim	Ore 10f. Zip Code			10g. Citizen of Wha	at Country?	
	s 23a	eral [	708 Pennsylvania						USA		
920	should be filed within 72 hours after death with the Maryland Ad Mental Hygiene. The first marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Evanillat must be notified at	by Funeral	1 □ Never Married 2 🕅 Married	Was Decedent 8 Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates:	ever in U.S.	13. Was Decedent of Hold of If Yes, specify Cub 1 □ Yes 2 ▼ No		pecity Yes or No o Rican, etc.)		American Indian, White, etc. African merican	
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121	within iene. <b>than</b>	dmo		College (1-4or 5-	+)	fe. DO NOT use retire borer	d)		a 1 .	Distillery	
nd		BeC	17. Father's Name (First, Middle, Last)	NA		Dorer	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	Discillery	
z Ja	d 2 should be th and Mental 7 is marked of traumatic ev	၉	Fiely Lipso				Goldie		lawkins	nto Zio Codo) MD •	
Z	hai hai 7 is trau		19a. Informant's Name/Relationship (Type. Goldie Hawkins-M	,		ailing Address (Street				21217 Baltimore	
Baltimore, Maryland 21215-0036	les 1 and of Healt if item 2 or other 1		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Rem	aval from State		sposition (Name of crematory or other pla		Date	20c. Location - Cit		
֟֝֟֝֟֝ <u>֚</u>	permit. Pages Department of Important; If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify)	oval IIoIII State	Mt. Zi	on Cem.	07-0	03-09	Lansdow	ne, MD	
Ba	Depa Impo any ii		21. Signature of Funeral Service Licensee	• •		22. Name and Addre	Wy	lie Fu	neral Ho	ome P.A.	
			23a. Part 1. Enter the disease, or complical shock, or heart failure. List only one	ons that caused use on each lin						Approximate Interval Between	
- 1	hysician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	6	Applopul		Ames			Onset and Death	
3	xaminer			Due to (or as a	PANCEA	Can	= 1				
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	physicia the buri		d		DIABETE	5 Mell	1 TVS				
. Box 687	ding pl	/Med	IF FEMALE:	If yes, outcome	of pregnancy	iliz.			00.1.0.1		
		hysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 🗆 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of Month	,	
ecords, P.U	en signed l	by P	Part II. Other significant conditions contrib	uting to death bu	t not resulting in th	e underlying cause giv	ven in Part I.			ute to the cause of death?  Probably 4 • Unknown	
I Kec	ate has be	Completed						24a. Was autop perfo 1 □Yes	rmed? 🖊   dea	re autopsy findings available or to completion of cause of tth? ]Yes 2 □No	
OT VITAL H	certific	Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 □ No Hos	oital:		- Ott		ath (Check only o			
on or	this certificate has stuneral director, page 2 s	ition: To	Tes 2 No	1 ∐ Inpatie 28a. Date of Injur (Month, Day	nt 2 ER/Outpa y 28b. Tim ; <i>Year)</i> Inju	e of 28c. Inju ry Wor	ry at k? Yes 2 □ No		dence 6 Other	(Specify)	
UIVISION	To the Funeral Director. After the completely filled in by the funeral	Certification: To	a Could not be	28e. Place of Inju building, etc	ry - At home, farm. . (Specify)	street, factory, office		28f. Location (: City or To		or Rural Route Number,	
ho Hoenid	in 24 hour	ca	29a. Certifier (Check only one) 1 ☐ Certifying Physici 2 ☐ Medical Examiner	On the basis of	examination and/o	or investigation, in my	opinion, death occu	urred at the time,	date and place, and	d due to the cause(s)	
į	To 1	2	29b. Signature and title of certifier		0	29c. Licens	se number		29d. Date signed (I	Month, Day, Year)	
		ŀ	30. Name and address of person who comp	leted cause of de	eath (Item 23a) (Tw	pe, Print)	D0066 5	07 420-4	JUNE	24, 2009	
			22 S. GREE	JE 51	TREET	BART	Thous	MD	21201		
	Sta Registra	te ar	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who comp  22- S. CAEE  31. Date filed (Month, Day, Year)  JUN 3 0 2009	Registra	r's Signature	arke		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 5aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 217-52-5593 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 0 23a Goodnow road apt. H Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced /ac "natural", Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (4-4 or 5+) diction other traumatic event, 17. Father's Name (First, Middle, Last) Be and Mental Fisher is marked of မ 19a. Informant's Name/Relationship (TV 19b. Mailing Address (Street and Number or Rural Route Number. Health a 05COh Method of Disposition 5016 other t 20b. Place of Disposition (Name of cemetery, crematory or other place, 3 ☐ Removal from State Department of H Important; If iter any injury or oth once. 1 Burial 2 Cremation 4 Donation 5 Other (Specify) rownsville 21. Signature of Funeral Service Licensee Greene Funeral Services Natt Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or held failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GI **Physician** Bleedir /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events death certificate be executed Due to (or as a consequence of): the burial-tra resulting in death) Last physician of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> No 3 🗌 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform certificate 2. 25. Was case referred to medical Physician: director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4  $\square$  Nursing Home 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 5 Residence 6 Other (Specify) this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 24 hours after death.

Funeral Director: After or Attending 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 June 25 2009

⟨ √ | State

31. Date filed (Month, Day, Year)

30. Name and

MARSH
32. Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

rate filed (Mortin, Day, Year)

SULIA

32. Registrar's Signature

Registrar

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death irst Middle. Year Month **Physician** 10:50 M 7004 /Medical 4c. County of Death City, Town. or Location of Death ame (If not institution, give street an Examiner tome 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show traumatic event, if a Medical Examin er must be notified at Baltimore 1 **So**es 2 □ No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21215 Hvenue items 23a 2 should be filed within 72 hours after death v and Mental Hygiene. Is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life: DO NOT use retired) ry (0-12) College (1-4or 5+) ames 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Be ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 1417 N. Ellamont St., Balto. 9a. Informant's Name/Relationship State, Zip Code) Balto. and 21216 20b. Place of Disposition (Name of cemetery, crematory or other page 200). Date City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign yur of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Hear /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) signed by the a d be detached for P.O. ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed After this certificate 2 No 1∐Yes 2.2KMo 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🛣 Natural 2 🔲 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avonue Burton Doboran 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

GG1 ABE.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Dav Year **Physician** 6:55 AM 2009 ELIZABETH ALVERTA ALSTON HIGGINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Ballimon Co If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV . 29 5. Social Security Number 6. Sex **Funeral** Months Year) Days 1 □ M 2 🛂 F MARYLAND 1924 Director 218-22-6197 84 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Expression must be notified at 1X XYes 2 □ No Director BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 3114 WOLCOTT AVENUE 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 XXVo Specify: BLACK þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th grade CARE TAKER is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental REGINALD LEE LILLIAN RUFF ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 2450 McCulloh Street, Baltimore, Maryland 21217 Gloria Gale/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury o 4 □ Donation 5 □ Other (Specify) 06-30-09 KING MEMORIAL PARK BALTIMORE, MARYLAND 21. Signatur undra 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Se /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 ☐ Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ş. 1 Yes Completed 24a Was an autopsy performed 2 MNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To . Date of Injury (Month, Day, Year) 28b. Time of Injury e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie RES - 000 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ad eamrat Sinai Hospital anom 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Birthplace (State or Foreign Country) 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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amend #7 Per Ana BD G893 //01/09 Jh State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Howard Lee Heinze June 23, 2009 4:29 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 X M 2 □ F 81 214-24-9929 **Director** Nov 26, 1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar is until by notified at 1 ∏Yes 2KINo Completed by Funeral Director MD Harford Abingdon 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 449 Clydebank Drive 21009 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No

If Yes, Give Year or Dates: 1944 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2K Married 1944 1948 Specify: white 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry Un 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) steel worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be i h and Mental Mildred Barnes Pages 1 and 2 should Joseph Alphonso Heinze 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. 449 Clydebank Drive Abingdon, Maryland 21009 Margaret Heinze/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation -3 Removal from State 4⊠ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street in Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. PHANYNGOR WHU SQUAMOUS CELL CARCINOMA Immediate Can e (Final disease or con a n resulting in death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ HYPOLITANSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed HAPULIDIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performeg DIMBETES TYPE ID certificate 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 □ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 meur po H40769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMMORRA NO SUME 220 BELAR MD 21015 2227 040 GREGORY M DOHMITER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 30

2009

Heinz, Howard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)  $2^{\text{pay}}$ **Physician** 2009 2:50 Рм June Nelson Y. Hunt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery Hospice Casey House Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March 21, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Year) 1918 **Funeral** New Jersey 1**X** M 2□ F 91 154-09-9118 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extrainer must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Director Maryland | Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20895 10208 Parkwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ∑Yes 2 □ No WWI If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No White Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military Hospital Maintenance Inspector 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be M. Mitchell Nelson Hunt ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important; If Item 27 is
any injury or other trau 10208 Parkwood Drive, Kensington, Maryland 20895 Aileen R. Hunt / Wife Date 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State June Montgomery Crematorium, Inc Bethesda, Maryland 2009 4 Donation 5 Dother (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee Myslette Sams M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical 88 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year for 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No s certificate ha lirector, page 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 1 🖪 Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred After t 28c. Injury at Work? **Hospital or Attending** 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number J. Kouertehou, mi) 163 748 June 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20rl 6001 Muncaster Mill Road, Rockville, Maryland 20855 Jocelyne Kouatchou, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signat JUN 3 0 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Virginia Mae Herold 2009 4:50 p. <u>June</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1941 Denbury Drive Baltimore Dunda1k Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2**X** F Months 225-46-3257 Director 5. 1935 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 No N/A Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 4329 Roberton Avenue 21206 United States
14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 \( \text{Yes} \) 2 \( \text{XNo} \) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. tem 27 is marked other thar Own Home 12 years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Loring Anderson Ada Mae Smoot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debora L. Collins (Executor) 18 Chattuck Court Middle River, Maryland 21220 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 3 Removal from State 5 Other (Specify) 6/27/2009 | Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility 21. Signatura Duda-Ruck Funeral Home of Dundalk, Wise Avenue Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year 5 ☐ Other (specify) the 9 Unknown signed by to d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only o e) vaugnters Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No neral Director: , filled in by the f 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signat 29c. License number cause of death (Item/23a) (Type, Print) ANI

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death A M June 26. 2009 1:50 Jeffrey Scott Hagan 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 01ney Montgomery Montgomery General Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 13,1965 5. Social Security Number 7. Age (In yrs, last birthday Hours Days 1 **□** M 2 □ F Maryland 44 216-52-9902 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 VNo Woodbine Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21797 USA 3128 Cabin Run 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hagan & Hamilton President 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Ann Hamilton Carroll Hagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3128 Cabin Run; Woodbine, MD 21797 wife <u>Sheila Hagan</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🗹 Other (Specify) Towson, MD Hilltop Service Corp 7/2/09 21. Signature of Fun-22. Name and Address of Facility 1050 York Road MD 21204 Towson, Ruck Towson Funeral Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Die to (or sels consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 - Ectopic pregnancy Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 2 □No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Director

Funeral

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Completed

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**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Exagination and the mottle of a

Baltimore, Maryland 21215-0036

burial-transi P.O. Box 68760, ending physician use as the burial attending p for use as signed by the a Division of Vital Records,

Examiner Physician/Medical þ Completed page 2 s Be Certification: To

After this certificate has or Attending Physician: hin 24 hours after death.

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that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

General Hospital,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zhang

JUN 3-0 2009

Chuanbo 31. Date filed (Month, Day, Year) Montgomer

32. Registrar's Signature

1 - For State Registrar

		1. Decedent's Name (First, Middle,	Last)						<ol><li>Date of Deal Month</li></ol>	th Day	Year	3. Time of Death
Physi	ician dical	CYNTHIA	MARIE	IBRAH	HIM				June	24	2009	7:00 a M
Exam		4a. Facility Name (If not institution,				Town, or L	ocation of	Death		4c. Cou	inty of Death	
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Funera	al		Sex 7. Age	(In yrs. last birth	nday) If Under	1 Year	If Under 2	4 Hrs.	8. Date of Birth (Month, Day	Voarl	9. Birthp	place (State or Foreign
Directo		218-80-1965	1 □ M 2 🛛 F	49 <sup>Y</sup>	rs. Months	Days	Hours		June 7			RYLAND
ס		Usual Residence of Decedent										
ylan <b>how</b>		10a. State 10b. County		10c. City, Town	or Location						1	10d. Inside City Limits
Mai a-fs	턍	MARYLAND HAR	FORD CO			EDGE	WOOD					1 ∐Yes XXXXo
h the	Director	10e. Street and Number			10f. Zip	Code	_		1	0g. Citizen	of What Cour	ntry?
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be filed within 72 hours after death with the Maryland tall Hyglene. All the Maryland of other than "natural", or items 23a or 28a-f show event, it at Medical Exprine must be notified at	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Deced	dent of His	panic Orig	in? (Spe	cify Yes or No-		Race - Americ Black, White,	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one)	and manner stat									
Vith Vith Co	Σ	29b. Signature and title of certifier	4		29	c. License	number	-		29d. Date s	igned (Month	, Day, Year)
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5	State	31. Date filed (Month, Day, Year)	32 Registra	_								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

20841

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21 46 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Days Months 600 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Myddal Eventine. I ust be notified a once. 1 ☐ Yes 2 V No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ∏ If Yes, Give Year or Dates 1 Never Married 2 Married 1 ☐ Yes 2 Mo Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EMPLOY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ATHENS, GEORGIA JAMES AVENUE 580 20b. Place of Disposition Name of cemetery, crematory or other place) 20c. L ation - City or own, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MKKVIUE MD SERVICES-PA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part 1. Entertithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Comey Vorallar De a Hyputernier Interioreunte /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 robably 4 Unknown Churcie Dechoratrice Polvena Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cerchrosonaisai performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 11No 1 Inpatient 2 DeR/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the builan-transit Box 68760, Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D19667 fluciace ( wastes) 06-26-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7310 2+clie Qua Borne, flangant \$ 508 32. Registrar's Signature

31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy 6893 7/06/09 Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Jones 2. Date of Death Marie 1. Decedent's Name (First, Middle, Last) Yea Month **Physician** 5 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 10W50 9. Birthplace (State or Foreign Country) Michigan 8. Date of Birth (Month, Day, Yea. if Unde curity Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 M 2 M May 20, 1923 86 Director 495-14-9377 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at onnes. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 27 No Director Middle River MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21220 1300 Windlass Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 177 k 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 government manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antoinette Heier Walter John Klefler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7001 N. Charles Street Towson, Maryland 21204 Manor Care Ruxton 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify State Anatomy Board 655 W. Baltimore Street Baltimore, Maryland 21201 21. Signature Konald rector Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Lenkenia Immediate Cance (Final disease or condition resulting in death) **Physician** wonic /Medical Due to (or as a consequence of) Examiner Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 5 ☐ Other (specify) Yes 2 No the 9 Unknown 9 TUnknown isigned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Certification: To

3 ☐ Suicide 4 ☐ Homicide 29a. Certifier Medical

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Bellona

29d. Date signed (Month, Day, Year)

Day, Year) JUN 3 0 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director		5. Social Security Nu. 215-70-69	993	. Sex	e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bird (Month, Da Aug 20	th y, Year) 1955		rthplace (State or Foreign ountry) hington DC
	land ow		Usual Residence of 10a. State	10b. County		10c. City, Tow	n or Loc	cation						10d. Inside City Limits
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	or 28	Director	10e. Street and Num					10f. Zip Code				10g. Citize	n of What C	ountry?
	eath v	Funeral	5412 O1d	Court	Road  12. Was Decedent	Ever in U.S.	13. V		133 Hispanic	Origin? (Sp	ecify Yes or No	- 14	USA . Race - Am	erican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, In. IM. Jicol Exp. in a minit be notified at once.	by	1 Never Marrie 3 □ Widowed	_	Armed Forces?			Nas Decedent of fYes, specify Cub			Rican, etc.)		Black, Whit	
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altimore, Maryland 21215-0036	Pages 1 and 2 nent of Health ant: If item 27 i ary or other tra		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation 3	□Removal from State	/ I	of Dispos ery, crem	sition (Name of natory or other pla	ace)	Γ	Date	20c. Loca	tion - City or	r Town, State
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	sath ce attendi for use	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat		Ectopic pregnar Other <i>(sp</i> ec <i>ify)</i>	псу			23	d. Date of de Month	elivery Day Year
σ.	w requires that the de been signed by the should be detached			cant condition	contributing to death b	ut not resulting	in the ur	nderlying cause g	iven in Pa	rt I.	23e. Did t	obacco use	contribute	to the cause of death?
rds	equires en sign uld be	ed by	Also	101- H	7 buse						1 🗆 '	Yes 2□	No 3□F	Probably Unknown
l Records,		Completed									24a. Was autor perfo	an osy ormed? 2 Da No	24b. Were a prior to death? 1 □ Ye	
Vita V	Physician: The Is this certificate ha al director, page 2	Be (	25. Was case referre examiner?	ed to medical	Hospital:				L		n (Check only o	nne)		V
ot	Phys r this or	2	1 Yes 2 Section 27. Manner of Death		1 Inpati	ent 2 ER/C	utpatien Time of	I SELDON			me 5 Resi			pecify)
on	nding P ath. r: After i e funera	ation	1 Natural 2 Accident	5 Pending investigat	(Month, Da	y, Year)	Injury	) Wo	rk? ⊡Yes 2		200, 2000, 200			
Division of Vital	al or Attending Physician: s after death. al Director: After this certific: ed in by the funeral director, g	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	20e. Flace Ut III]	ury - At home, f c. <i>(Specify)</i>	arm, stre	eet, factory, office			28f. Location ( City or To		Vumber or F	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination a	ge, death and/or inv	n occurred at the vestigation, in my	time, date opinion, d	and place, death occur	and due to the red at the time,	cause(s) a date and p	nd manner a lace, and du	as stated. ue to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and t	itte of certifier	1.10A	7		29c. Licer				29d. Date	signed (Mor	nth, Day, Year)
		-	30 Name and address	ass of namon and	no completed cause of c	leath (Item 220)	(Time	Print)	100	ro	1	JUA.	210	,2001
			5+	even	J. Sc.	Can (Heili 23a)	(Type,	56 A	het's	ups	+ 4	Joip	ifal	Center
	Sta Registr		31. Date filed (Monti	h, Day, Year)	32. Registr	ar's Signature	bark	Les .				,		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland	-	rtment e tificate			d Mental Hy	giene Reg. No. 🗥	000	00015		
			Registrar  1. Decedent's Name (First, Middle,	Last)						2. Date of De	-	003	3. Time of Death		
	Physicia		PIERCE H.	JONES,	JR.					JUNE Month	27,	2009	2:14 A M		
*	/Medic Examin		4a. Facility Name (If not institution,				4b. City, To	wn, or	Location of De	eath	4c. Cou	nty of Death			
	LXanni		107 CHESTNUT S	TREET			TURI	NER	STATIC	)N	BALTIMORE				
	Funeral		5. Social Security Number	6. Sex 7 1 ★M 2 ☐ F	. Age (In yrs. las	st birthday)	If Under 1	Year Days	If Under 24 h	Hrs. 8. Date of Bir Min. (Month, Da	th av. Year)	9. Birthp	place (State or Foreign		
	Director		220-14-1091	1 <u>4</u> M 2 L F	85	Yrs.	MONTHS	Days	110010	01-11-	-1924		MD		
	nd >		Usual Residence of Decedent  10a, State 10b. County		100 City	Town or Loc	notion					1	0d. Inside City Limits		
	aryla shov	'n	,										1 X Yes 2 □ No		
	the M	Director	MD BALTI  10e, Street and Number	MORE	T	JRNER	10f. Zip C				10g Citizen	of What Cour	ntry?		
	a or		107 CHESTNUT S	трггт				2122	22		US				
	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  s marked other than "ratural", or items 23a or 28a-f show maric event, the Medical Examiner must be matthed at	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. V				? (Specify Yes or No		Race - Americ	can Indian,		
<b>'</b> O	riten	Fur	1 ☐ Never Married 2 Marrie	Armed Force 1 XYes 2	es? . □ No			10		? (Specify Yes or No uerto Rican, etc.)	E	Black, White,	etc.		
9	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es: WWII	1	l∐Yes 2	<b>X</b> No	Specify:		Spe	cify: BLA	ACK		
O L	72 hor	Completed	15. Decedent' (Specify only highest	s Education		16a. Deced	dent's Usual (	Occupa	ation Juring most of	working	16b. Kind o	f Business/Inc	dustry		
21:	e. an "r	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	OO NOT use	retired,	)	Working					
21	ed wit	S		3		SHI	P FIT	TER				ILEHEM	STEEL		
p	oe file tal Hy d oth	Be (	17. Father's Name (First, Middle, L							Name (First, Middle	, Maiden Surr	name)			
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	၉	PIERCE H. JONE	S, SR.					MARGA						
Jar			19a, Informant's Name/Relationsh CLARICE E. JON				ng Address (S CHESTNI			r Rural Route Numb		wn, State, Zip L <b>222</b>	Code)		
ď	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene.  If filem 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examine must be refilled at			LD, WIIL	not Die		sition (Name			Date		on - City or To	ywn State		
altimore,	iges it of l		20a. Method of Disposition  1	3 ☐ Removal from St	ate cer	metery, cren	natory or othe	er place				•			
ੜੋ	t. Pa rtmer rtant rjury		4 □ Donation 5 □ Other (Sp		CRU		LLE VI			7-6-09		SVILLE	F.H.,INC.		
Ba	permit. Pages 1 Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service L	icensee					AURENS		CIMORE,		21217		
	202 4		23a. Part I. Enter the disease, or o	for	on dooth							, 110 2	Approximate		
			shock, or heart failure. List o	only one cause on each	ch line.	Do not ent	er the mode	Ol dylli	g, suon as can	alac of respiratory (	317031,		Interval Between Onset and Death		
Sant Congression of	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):												
1	Examiner		,	Due to (o	r as a conseque	ence of):									
		in in	Sequentially list conditions,	b. — Due to (o	r as a conseque	ence of):						-			
ىل	nsit	in L	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	240 10 (0								- 4			
بر مر	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a conseque	ence of):							<del></del>		
8760,	ficate be executed physician and s the burlal-transit	dical		d											
9	ifficat g phy as the	edic		U							- 4				
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			3=				23d.	Date of deliv	ery		
ñ	death d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	th 2□Fetalo int at time of de		Dectopic pre					Month	Day Year		
P. 0	t the by th	hys	9 Unknown	9 Unkno	wn										
ώ.	w requires that the di been signed by the should be detached	by P	Part II. Other significant condition	ns contributing to dea	th but not result	ting in the ur	nderlying cau	ise give	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?		
ğ	quire an sig									_ 1□	Yes 2 □ N	o 3□ Pro	bably 4 Unknown		
ပ္က	aw re	Completed								24a. Wa		4b. Were auto	opsy findings available		
ž	Physician: The law r this certificate has ral director, page 2 s	E O								euto	ormed? 2 DANo	death? 1 □ Yes	ompletion of cause of		
ta	an: '	Be C	25. Was case referred to medical	1.					26. Place of	1 □Yes Death (Check only		1 🗆 163	2,500		
>	ysici is cel direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2 🗆 E	R/Outpatier	nt 3 🗖 DOA	Othe		\ .	idence 6 🗆	Other (Speci	f(y)		
0	ding Ph h. After thi funeral	ü	27. Manner of Death	28a. Date of	Injury 2 , Day, Year)	28b. Time of Injury	f 28d	c. Injury Work	y at	28d. Describe	how injury oc	curred			
ō	ath. r: Af	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	, Day, rear,	ju. y	М		Yes 2□No						
Division of Vital Records,	I or Attend after death Director: /	tig	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Place of building	f Injury - At hom g, etc. (Specify)	ne, farm, str	eet, factory, o	office			(Street and No	umber or Rur	al Route Number,		
٥	ital o	Certification: To		N											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical E	Physician: To the because of the base											
	the f hin 2. the F mplet	Medical	one)	and manne						~					
	6 <b>5</b> kg	=	29b. Signature and title of certifier				290.	License	e number		Zad. Date SI	gned (Month,	Day, 16al)		
			/ayon,	(lle)			1	00	212	42	peno.	30, 3	200		
	1/41		30. Name and address of person y	who completed cause	of death (Item:	23a) (Type,	Print	rple	ell Be	ved Sell	k 20.	3 /			
	Sta	to	31. Date filed (Month Day, Year)	1(4 M) 32. Re	gistrar's Signatu	Bal.	10, W	d	218	2.5%					
	Sta Registr		IIIN 3 0 2000	' A	1. 1	back	1								

DHMH 17 Rev 1/2001

2. Date of Death

Day

21236

Baltimore, MD

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Modical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

n al	Charles	Walter .	Johnson	III						June	June 24, Day 2009 11:50				
ar er	4a. Facility Name (If	not institution, giv	ve street and nu	mber)		4b. City,	Town, or	Location	of Death			c. County of	Death		
	306 Barl	ksdale Ro	oad			Joj	ppa					Harfo	ord		
	5. Social Security Nu			7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Yea	r) 9	Birthp Coun	ace (State	or Foreign
	217-22-6	7213	1 X M 2□ F	80	Yrs.					Aug.		1928 1			
	Usual Residence of			10- 0	. Town and	- ation							14/	d. Inside C	Pity Limite
ڀ	10a. State	10b. County		ty, Town or Lo	ocation							10		s XXNo	
엉	Maryland	Baltimo	ore	Dı	unda1k						To tes 2200				2 E-1410
<u>ir</u>	10e. Street and Num	nber				10f. Zip	Code				10g. (	Citizen of Wha	at Coun	try?	
<u>a</u>	49 Yorkwa	ay				2	1222				Uni	ited St	ate	S	
Completed by Funeral Director	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Deced	dent of H	ispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race -	Americ White, e		
ī	1 Never Marrie	ed 2💢 Married	1 XYes If Yes, Gi			1 □Yes		Specify:		, , , , , , , ,		Specify:			
ğ	3 ☐ Widowed 4	4 ☐ Divorced	Year or D	ates:		1 🗆 100	L MILES	Op dony.				эреспу.	WILL	LE	
ate c	(Speci	15. Decedent's E	ducation		16a. Dece	dent's Usua kind of wo	al Occup	ation	t of work	ina	16b.	Kind of Busin	ess/Ind	lustry	
ğ	Elementary/Secon		College (		life.	DO NOT us	se retired	1)		9					
ပ်			+3		Elec	tricia	an					Self-Er	<u> 1</u> p10	yed	
Be (	17. Father's Name (	First, Middle, Last	t)					18. Moth	er's Nam	e (First, Middle	e, Maide	en Surname)			
힏	Charles V	Valter Jo	ohnson,	Jr.				Luci	11e	Kidwel	1				
	19a. Informant's Na	me/Relationship	(Type. Print)		19b. Maili	ng Address	(Street	and Numb	er or Rur	al Route Num	ber, City	or Town, St	ate, Zip	Code)	
	Audrey Jo	hnson	(Wife)		74	Nentu	ne D	rive	Jo	nna. M	arv1	and 21	085		
	20a. Method of Disp	osition		1 /	Place of Disponentery, cre	osition (Nar	ne of	(a)		ppa, M Date	20c.	Location - Ci	ty or To	wn, State	
		ີ Cremati <i>o</i> n 3 ⊑ 5 □ Other <i>(Sø€ດິເ</i>		State	keview				une	29, 20	09	Sykesy	7 <b>i</b> 11	e. Md	
		ne al Service Lice			2	2. Name ar	nd Addres	ss of Facili	ty						
1	/ lil	W/X	2//	0.						Home o					
-	23a. Part 1. Enter th	e disease or com	unlications that	caused the deat						Dunda1 or respiratory		Marylar	1d + 2	Approxima	ate
	shock, or hear	t failure. List only			20 1101 011		o o ay	9, 000, 00						Interval Be Onset and	etween
	Immediate Cause (I disease or condition resulting in death)		a. Meta	static	Non-St	na11 (	Ce11	Lung	_Can	cer			3	Mont	hs
	resulting in death)	•	Due to	(or as a consec	quence of):										
_	Sequentially list con	ditions.	b												
cian/Medical Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or i that initiated events	nediate lying	Due to	(or as a consec	quence of):										
сап	that initiated events resulting in death) L	njury	C	·									_		
Ω —	resulting in death) L	ası	Due to	(or as a consec	juence ot):										
ica		•	d										-		
Mec	IF FEMALE:														
an/l	23b. Was decedent			tcome of pregn birth 2 \(\subseteq\) Feta		☐ Ectopic p	reananc	v				23d. Date of		ery Day	Year
sici	in the past 12 r 1 ☐ Yes 2 ☐			nant at time of		Other (sp						IVIOITU	1	Day	Teal
	9 ∐ Unknown											11 17 -			
by Phy	Part II. Other signifi	cant conditions	contributing to d	eath but not res	sulting in the u	ınderlying c	ause give	en in Part	l.			o use contrib			
ed										1 🗆	]Yes	2 <b>X</b> No 3	☐ Prob	ably 4 🗌	] Unkn <i>o</i> wn
Completed										24a. Wa		24b. We	re auto	psy finding	s available
Ĕ										per	opsy formed?	dea	ath?	mpletion of	cause of
	25. Was case refern	od to modical	1				-	00 81	( D	1 Tyes		Vo 1L		2 🗆 No	
Be	examiner?		Hospital:		1.60/0 : ::		Oth	or:		h (Check only		4E ou		0	er's
<u>۲</u>	1 Yes 2X1 27. Manner of Death		28a. Date	_ <u>·</u>	28b. Time		DA   28c. Injur	4 🗆 14	ursing Ho	ome 5 Re				W Kesi	dence
ion	1 X Natural	5 Pending	(Mor	nth, Day, Year)	Injury	M	Worl	k? Yes 2□	No	ZOG. DOGOTIDO	7 11044 111	july cocurred			
cat	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b		n of Indiana At In	ana farm et			105 2	140	20f Location	/Ctroot	and Number	or Bure	d Pourto Nu	mhor
ŧ	4 ☐ Homicide	determined	ZOC. Flace	e of Injury - At h ling, etc. <i>(Speci</i>	ify)	reet, ractory	, OHICE			28f. Location City or To			or nura	ii noute Nu	mpor,
ပ္	OOO Contifies	<b>157</b> 0		- h t - t t	a dede : -	Ala a a servicio	Label Con			and desired		(a) and		totod	
ca		Certifying P													(e)
		Z   Wedical Exa		basis of examin	ation and/or i	livestigation	i, iii iiiy ¢	plinion, de	atti occu	ned at the time	e, date a	and place, an	a aue to	tne cause	(3)
Medical Certification: To	one) 29b. Signature and t			ner stated.	ation and/or i		-	e number	atti occu	Tred at the time		Date sign <i>e</i> ti (			

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0+11

Suite 208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashkan Bahrani, M.D. 9114 Philadelphia Road

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month. Year **Physician** ス 2009 Edward Charles August Klein MAR /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Citizens N 5 Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace Country) (In vrs. last birthday **Funeral** Min Hours 1 XM 2 ☐ F 351-20-1394 85 06-02-1924 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 14. Race - American Indian, 3719 Sewell Rd 21009 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after Hyglene. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: White 3altimore, Maryland 21215-0036 Specify \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Draftsmen Bendix Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be file and Mental H Be Edward Klein Emily Scherer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum once. Edward Klein (Son) 316 Ewing St Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Baltimore Cemetery 06-26-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) 0 SS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) P.O. Box 68760. physiclan Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by a page 2 should be detach 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autoosv perform certificate 2 No 1□ Yes ein, Edward Attending Physician; 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c∉rtifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Levolution St M115 am MD 1100 Kamnich 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Year Month **Physician** 2:20 A M Jack G. Kamps, Sr. June 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 80 212-26-7225 Maryland Director April 21, 1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygelen. "Introducing", or items 23a or 28a-f show Important; if item 72 is marked other than "natural", or items 23a or 28a-f show any injunt; or other traumatic event, the "Marial Eurning" could be notified at Director Baltimore Spearks 1 ∐ Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16405 Yeoho Road 21152 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White à 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ferdinand Kamps Margaret L. Phebus ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriet Kamps/ Wife 16405 Yeoho Road, Sparks, MD 21152 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Dularey valley 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/30/09 4☐Donation 5 ☐Other (Specify) Timonium, MD Memorial Gardens 21. Signature of Funeral Service Licensbe 22. Name and Address of Facility Evans Fureral Chapel & Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or respiratory arrest, shock, or repart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): 16924 York Road, Monkton, MD 21111 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, it any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (ur as a nunsiquence of) law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2000 certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Vital Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Other: 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Jepital c. 4 hours after des. \*\*eral Director: Ah Vatural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 29, 2009

Registrar

DHMH 17 Rev 1/2001

State

JUNE

ACK KAMPS

TIMONIUM, MD 21093

2300 DULANEY VALLEY ROAD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

AUN 3 0 2008

31. Date filed (Month, Day, Year)

			State Registrar	, , , , , , , , , , , , , , , , , , , ,	Cer	tificate of	Death	,	Reg. No. 2 (	009	20845
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		STEWARD A. KOGE					JUNE 27	200		12:27 P M
	Examin	er	4a. Facility Name (If not institution, give street				r Location of Death		4c. Count	of Death	
and the			MARYLAND GENERAL HO 5. Social Security Number 6. Sex	7. Age (In yrs. la.	et hirthday)		IMORE, MD If Under 24 Hrs.	8 Date of Bir	th	9. Birth	place (State or Foreign
	Funeral Director		215-46-8230 Usual Residence of Decedent		Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 07-08-		Coul	
	aryland show		10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mary -f sh	tor	MD	В	ALTIM	ORE					X Yes 2 No
	ith the Mar or 28a-f sh	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	h with		2525 REISTERSTOWN I	D.		2	1217		U	SA	
	ems	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S. med Forces?	13. V	Vas Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ce - Ameri	can Indian, etc.
920	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, it e Mysical Examiner mast to notified at	by	1 Never Married 2 Married If 1 Never Married If You	TYes 2 No res, Give ear or Dates: 66-69	1	□Yes 2▼ No	Specify:			fy: BLA	ACK
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade com		16a. Deced	ent's Usual Occup	pation during most of work	ina	16b. Kind of E	Business/In	dustry
2121	J within 72 ho giene. r than "natur ir e Medical	Completed		U (4 4 F.)	LABOR		during most of work d)		BALTO C	ITY I	EPT ED
Maryland 21215-0036	s 1 and 2 should be filed i f Health and Mental Hygi tem 27 is marked other other traumatic event, it	To Be C	17. Father's Name (First, Middle, Last)  ERIC COGER				18. Mother's Nam	e (First, Middle ET COOK		me)	
Mary	nd 2 should be fi lith and Mental H 27 is marked ot r traumatic evel		19a. Informant's Name/Relationship (Type. P. ROSIE MARIE COLES/DI			-	and Number or Ru				
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ Remove	20b. Pla	ace of Dispos metery, cren IG MEM	sition (Name of natory or other place	ce) 07/0	Date <b>8/2009</b>	20c. Location		own, State
3altin	ermit. Poppartme popurtani ny injury injury injury injury ince.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Mat							NS F.H., IN
	20 = 4 O		& ames q.	youm			RENS ST.,			21/	Approximate
	Physician /Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car immediate Cause (Final disease or condition resulting in death)	Is that caused the death. Ise on each line.  ORDNAR  Due to (or as a conseque	Y F	RTERY	Di S.Z.				Interval Between Onset and Death
T	Examiner	<u></u>	Sequentially list conditions, b. —	Due to for so a consequent							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or).						
68760,0	icate be executed physician and the burial-transit	Exal	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):				-		
192	te be iysicia ne bur	cal	d								
89	ertifica ling ph e as th	Medical	IF FEMALE:								
O. Box	Attending Physician: The law requires that the death certificate be executed r death. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/I	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnan  □ Live birth 2 □ Fetal o □ Pregnant at time of de □ Unknown	death 3	Ect <i>o</i> pic pregnand Other <i>(specify)</i>	су			ate of deliv	very Day Year
σ,	that ned b deta	y P	Part II. Other significant conditions contribute	ing to death but not result	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
r S	quiree on sig	d by						í <u>z</u> t	¥ues 2 □ No	3□ Pro	obably 4 ☐ Unknown
Division of Vital Records,	ician: The law recertificate has bee ector, page 2 shore	Completed						24a. Was auto perfe	ormed?	death?	opsy findings available ompletion of cause of
ta	in: T tificat or, pa		25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	272No	1∐Yes	2 □No
<u> </u>	ysicia is cer direct	o Be	examiner? 1'⊠Yes 2 ☐ No Hospit	al: 1 Mnpatient 2 □ E	R/Outpatier	t 3 DOA Ott	oer:	ome 5 Res		ther (Spec	ify)
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ivisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str				Street and Nur wn, State)	nber or Ru	ral Route Number,
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	the H iin 24 the F	Medical	one)	nd manner stated.							
	<b>5</b> wit	2	29b. Signature and title of certifier			29c. Licens			29d. Date sign	_	
			1 / yee MU		\ '		30749			29-	0 4
	3+1		30. Name and address of person who comple	ted cause of death (Item	23a) (Type,	reene ?	ST. BAIL	IMORE	MD 2	-120	(
	Sta Registr		31. Date filed (Month, Day, Year)	ted cause of death (Item	fare	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 **Physician** 26 2009 02:15 Koehler ам Bettv /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Harford Gardens Harborside Healthcare Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗓 F Months 03/03/1934 Maryland 75 Director 213-30-1327 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examinal must be notified at 10a. State 10b. County 1 XYes 2 □ No Director Baltimore MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21214 4524 Arabia Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: If Yes, Give Year or Dates: à 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christine E. Kattenhorn William Charles Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 S. Sharp St. Baltimore, MD 21201 Tina Hall, Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06/30/2009 Baltimore, Maryland Parkwood Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Elevandua S 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Day 5 ☐ Other (specify) 1 ☐Yes 2√No P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No certificate 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06-26-2009 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eet #308 Baltinoae, Mazizo1

State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 18 per FH, G893, 7/1 (09), WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Catherine D. Kuehne 2009 <u>lune</u> 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Canton Harbor Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F 217-09-2141 Director 88 December 4, Maryland 1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examinar must be notified at Director Baltimore 1 ☐ Yes 2 ☐ No Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Mavista Avenue 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No þ Specify: Specify: White 3 ₩ Widowed 4 □ Divorced "natural", Ye ar or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Seamstress Uniform Company 17. Father's Name (First, Middle, Last) 18. Mother Dearna (Eirs Weighte Maiden Surname) Be Charles Kruse Isabelle Ramsey ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Daughter Philemena Tagg 11 Mavista Avenue, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Important: If It any Injury or o July 1, 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Md. 23a. Par 1. Enter the disease, and implications that caused the shock, or heart failure. List only one cause on each line. mplications that caused the deat o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cereboovasa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami sician and burial-trans law requires that the death certificate be execu Due to (or as a consequence of) physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown funeral director, page 2 should Be Completed nemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has or Attending Physiclan: The Dementia performed certificate 2 □No 1 □ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 🖜 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is a provinced at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: filled in by the Hospital completely

> 30. Name and address of person who completed cause of death (Item 23a) (Type Print) hintan Desai 301 31. Date filed (Month, Day, 32 Registrar's Signature <sup>Year)</sup> 3 0

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) Oc

28

Medical

State Registrar (Check only one)

29b. Signature and the of certifier

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** 10:57AM JHC /Medical 4b. City, Examiner f Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday, If Und **Funeral** Months Days 1 ☐ M 2 🖾 F Yrs 21, 1930 Virginia 220-22-2553 78 Dec Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Experient rest by rightled at 1 ☐ Yes 2K No Director MD Baltimore Glyndon 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 47 Railroad Avenue 21071 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Staines John Wilson Estelle ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21071 Richard M. Klinefelter Husband 47 Railroad Avenue Glyndon, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Ser 7/1/09 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 11824 Reisterstown Road ron Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed **Box 68760,** 汝 burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) P.O.

sate has been signed by page 2 should be detach this After 1 within 24 hours after deam.

To the Funeral Director: / hours after death.

3

Be Completed

Certification: To

Medical

Records,

Division of Vital

4 Pregnant at time of death

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autonsy

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

performe 1 TYes 26. Place of Death (Check only one)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of D	eath
1 Natural	
2 Accider	nt
2 Cuicido	

29a. Certifier

5 Pending investigation 6 Could not be determined 4 Homicide

25. Was case referred to medical

2 🗆 No

2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

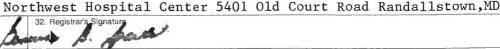
Lamont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

C. 31. Date filed (Month, Day, Year)

Smith



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician 10:00 P M 24, Daniel Victor Leftridge 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 15 M 2 F July 18, 1943 Maryland Director 65 215-44-2211 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Exercities" in ust be notified at 1 ☐ Yes 2 X No Director Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21154 1280 E. Macton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government Police Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Denton Leftridge Clara Hazel Reedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an Important: If item 27 is m. any injury or other 1000. 19a. Informant's Name/Relationship (Type. Print) Christine M. Kovacs / Daughter 1280 E. Macton Road, Street, MD 21154 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gdn. 7-1-09 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastatic carcinoma o **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): rimarc Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò 1 ☐ Yes 2 F No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier h. D. June 25th 2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo Min (In J.) 602 South Atwood Road # 200, Bel Air, MD21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 3 0 2009 Registrar

DHMH 17 Rev 1/2001

Mccccq5079

eftridge, Daniel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 1:30 PM 2009 KYUNG June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD OLUMBIA TOWARD COUNTY GENERAL HOSP ITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2**X** F Months Days 216-19-4294 87 South Korea 1/19/1922 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at MD Howard Columbia 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6334 Cedar Lane 21044 South Korea Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify: Specify: Asian à 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Poo Ji (unknown) Park ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Michelle Kim / Granddaughter 9557 Mountwoods Drive, Manassas, VA 20110 permit. Pages 1 and Department of Heath Important: if Item 27 any Injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/2009 Ardent crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final Physician espira day disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner gestive 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy aneuns 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2 No 2 ER/Outpatient 3 DOA 1 Thpatient Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ca To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature enotitile of certifier D36845 June 28,2009 MD, +CCP

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man-Clin Uguyen, MD, FCCP
7350 Grace Inve, Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20855 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1129AM 2 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Himore Ba Nercy Medica If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
DEC 27, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. Months 1 X M 2 □ F Days ,1938 MARYLAND 217-34-5092 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "molical Examinar", and be notified at 1X Yes 2 □ No Director N/A MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 813 S. 21231 ANN STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: WHITE þ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) NATIONAL CAN CO. MECHANIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENTZ, SR. ADAM VIRGINIA WYATT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ant; If item 27 is lury or other trau 726 DURHAM STREET, BALTIMORE, MD. IRVIN LENTZ/ BROTHER 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 6/29/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 12-12-WGe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner levis Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-trans therosclerosis Due to (or as a consequence of) P.O. Box 68760. Physician/Medical signed by the attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Yes 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Jas autopsy 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1∐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of 1 eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No al or Attendi s after death. I Director; A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 109

State Registrar 31. Date filed (Month, Day, Year)

JUN 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,28a,c per dr. 8892,06/30/09dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 09034M Love 00 SAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mercy medicay CITV Center Baitmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F 26450 1054 Director 0 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mychall Expriser, until be netified an once. Director 1 ☐Yes 2 WNo alen Dale 10f. Zip Code 10g. Citizen of What Country? 20769 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ρ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ttendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar Be Informant's Name/Relationship Barbara ate Dr. 20a. Method of Disposition 20b. Place of Disposition (National Commetery, crematory or commetery) 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signatury of Funeral 39 23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Datetes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): and burlal-trar Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ξ 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Ś signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💆 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? Hospital or Attending 24 hours after death. Natural 2 Accident 5 Pending investigation 1 ☐ Yes neral Director: / y filled in by the f 20109 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 24 and manner stated. the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar raci

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MD

32. Registrar's Signature

301St Paul

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thoureen

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No. 0 9	20857
		Physici /Medic			3. Time of Death
		Examin		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PIKESVILLE BALTIM	10RE
		Funeral Director		224-14-3054 1 M 2 M F 87 Yrs. Months Days Hours Min. (Month, Day, Year) 03/01/1922	ace (State or Foreign try) VA
		yland			Od. Inside City Limits
		he Mar 28a-f si	Director	MD BALTIMORE PIKESVILLE  109. Street and Number 109. Citizen of What Country	1 ☐ Yes 2 🐧 No
		h with t	ai Dir	7920 SCOTTS LEVEL ROAD 21208 USA	iy:
	036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23e or 28a-f show or other treumatic event, Ite Madical Examinant to notified at	by Funerai	3 X Widowed 4 Divorced Specify: Specify: Specify: WHI	etc.
	Baltimore, Maryland 21215-0036	d within 72 ho piene. r than "natur II.e Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  BOOKKEEPER  16b. Kind of Business/Indi JOS A. BANK CLOTHIER	
	nd	be filed ital Hyg od other event,	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	TN
	aryla	should ind Men inarke umatic	T <sub>O</sub>	ABE R COHEN ROSE SKLAR  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or Town, State, Zip or T	
	e, M	1 and 2 Health a em 27 Is		MARK ROSENBLOOM / FRIEND 6221 WALBOROUGH CT., GLEN. ALLEN, VA 23  20a. Method of Disposition (Name of Date 20c. Location - City or Tow	059
	mor	Pages nent of H		1 Magnial 2 Cremation 3 Magneton State  1 A Donation 5 Other (Specify)  1 A Donation 5 Other (Specify)  1 A Donation 5 Other (Specify)  1 A Donation 5 Other (Specify)  1 A Donation 5 Other (Specify)	
	Balti	permit. Page Department of Importent: If any injury or once.		21. Sign three of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE.	INC. MD 21208
				Immediate Cause (Final	Approximate Interval Between Onset and Death
		/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	76 mon14
		Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	
K	8760,	ate be executed hysician and the burial-transit	ai Examiner	that initiated events c. Due to (or as a consequence of):	
	9	ate hy:	Medic	d.  IF FEMALE:	
	P.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	ny Day Year
		w requires that been signed b should be deta	by	Part III, Other significant continuous continuous to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the arrow to the	
ian	Division of Vital Records,	4 01	Completed	24a. Was an autopsy performed?   1   Yes 2 No 1   Yes	psy findings available inpletion of cause of
Re	Vita		To Be	25. Was case referred to medical examiner?	/)
$\leq$	n of	iing Phys After this funeral di			,
evine, Mariar	Divisio	deatl deatl ctor: / the	Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural City or Town, State)	I Route Number,
3	<i>S</i> .	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as standard or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	
	5	To the vithin To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D	Day, Year)
				30. Name and address of prison who completed cause of death (Item 23a) (Type, Print)  Symul Lay and 2434 h Believelese are fullimon	=214
		Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sphature	

09-04847 Charles David M	litch	Please Type or			o <b>le Ink. Ensur</b> nt of Health an			le.	
Chancs David IV		1- For State	n iviai ylailu /		te of Death	iu ivieritai riy	rgierie Reg. N	. 200	9 2085
Physicia	ın/	Registrar  1. Decedent's Name (First, Middle,Last)			= 0.10 · /		2. Date of Death		3. Time of Death
Medical Exami	ner	CHARLES I	DAVID	171	ITCHELL	r Location of Death	Month Day June 19, 2009	4c. County of Deat	0828 hrs
A		4a. Facility Name (if not institution, give 8382 Fishing Island Road	street and number)		Upper Fairr			Somerset	
Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last birtho	day) If Under 1 Yea	ar If Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY) 9. Bi	
Director		212-98-0734 121	M 2 F	28	Yrs. Months Day	s Hours Min.	01/18/1	98/ Forei	ountry) MARYLAND
	ŀ	Usual Residence of Decedent							
W any		10a. State 10b. County		0c. City, Town or					10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f show	횼	New York ONOND  10e. Street and Number	AGA	JYR	ACUSE 10f. Zip Code	_	10a. C	itizen of What Cou	
or 28s	Director	480 PLEASANTYI	EW AVEN	1138	1.30	208	()	S.A.	,
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be cotified at once.	ral	11. Marital Status	12. Was Decedent E		13. Was Decedent of Hi	spanic Origin? ( Sp			rican Indian, Black,
death or iten	Funeral	1 Never Married 2 Married		∂ No	If Yes, specify Cuba		Rican, etc.)	White, etc.	. —
s after	ğ		f Yes, Give Year or Dates:	1 1 10 8	1 Yes 2 No		14Ch	Specify: 40	
hours natu	ted	15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	y highest grade comp College (1-4 or 5+	dı	ecedent's Usual Occupa uring most of working life	ation (Give kind of w e. DO NOT use retir		. Kind of Business	rindustry
336 thin 72 ne. than edical	Completed by	Liamentary, consumption (c. 12)	g- (	<u> </u>					
5-00 led will stygien other		17. Father's Name (First, Middle, Last)	2.11	//		)	(First, Middle, Maide	1	
121 d be fil ental I arked vent,	Be	Charles 1.	1/i+chEi	//		BEVERLY	SEAN	FINDER	
MD 21215-0036 11 should be filed within 7 12 should be filed within 7 11 should be filed within 1 127 is marked other than umartic event, the Medical	은	19a. Informant's Name/Relationship (Ty		\	Mailing Address (Stre		1 1	. /	(1) 21871
and 2 lealth item 2 traum	2000 T	KIAUS P. MITTINES 20a. Method of Disposition		20b. Place of	Disposition (Name of ce			c. Location - City o	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner		1 Burial 2 Cremation 3	Removal from State	cremator	y or other place)	2011	makero 1	alkmore	Mary land
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than injury or other traumantic event, the Medical		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	ee	VI 1877 U	22. Name and Addres	s of Facility	x/ xcc/ C	74/7///////	HIM
		& which N	. Willes	ams	22. Name and Addres うつらミア州 州 メイクハ・デク	110000	16-162176111	1101211	11/00/01/
Physician /Medical		23a. Part I. Enter the disease, or compli- failure. List only one cause on each	h line.					shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease a. or condition resulting in death)	Atheroscle	erotic c	ardiovascu	<u>lar disea</u>	se		Death
, .		Sequentially list conditions, b	ue to (or as a conseq	querice or),					
	ner		ue to (or as a conseq	uence of):	-	·			
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
executed an and al - transit	Ê	d	00	0.7	<del>(III - 00/ 07/</del>	7.700 mm			
ial ial	dical	X UNPENDED	AMENDED 23a	,2/,perm	ſΕ, g894 8/	6/09 11			
Box 68760, e death certificate be the attending physicized for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	of pregnancy	Fetal death 3	Ectopic pregna	1	23d. Date of delive Month	ry Day Year
IX 61	icia	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at til		Other (Specify)				
he d the	چ	Part II. Other significant conditions	9 Unknown	but not reculting	in the underlying cause	given in Part I	23e Did tobaco	co use contribute to	the cause of death?
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the d ris after death.  **I Director: After this certificate has been signed by the lied in by the funeral director, page 2 should be detached	2	Tarri. Onler algumean conductions	contributing to death i	but not resulting	in the underlying educe	givoir iii i dicir.			bably 4 Unknown
cords, P.O. law requires that has been signed be seen signed be a sequestive.	Completed						24a. Was an	24b. Were a	utopsy findings available
e law i e has b	直		<del></del>			_	autopsy performed		completion of cause of
tal Rec		25. Was case referred to medical			26.Plac	e of Death (Check		10	2 110
Vital hysician: this certiful director,	o Be	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient	t 2 ER/Out	patient 3 DOA	Other Nursin	g Home 5 Res	idence 6 🗹 Oth	er: Scene
ing Pt After After	اقا	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	y 28b. Ti		ury at Work?	28d. Describe how	injury occurred	
SiOn trend death. ctor: y the f	atic	1X Natural 5 Pending 2 Accident Investigation			J	Yes 2 No			I D. C. M. when Oile
Division of pital or Attending Plours after death.  eral Director: After iffiled in by the funeral	Certification:	3 Suicide 6 Could not b	e 28e. Place of Inju	iry - At nome, fan	m, street, factory, office	building, etc.	or Town, State		tural Route Number, City
E 5 5 E		4 Homicide  29a. Certifier 1 Certifying Physicia		knowledge, deat	h occurred at the time, o	date and place, and	due to the cause(s)	and manner as sta	ated.
To the How within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:							
- F 3 F 8	Me	29b. Signature and title of certifier	The state of state of			se number		d. Date signed (M	onth, Day, Year)
		U-MUL	- IWO		O.C	.M.E.	Jı	une 20, 2009	
		30. Name and address of person who con Donna M. Vincenti, MD	ompleted cause of de Assistant Medica		111 Penn Street	t Baltimore M	D 21201		
9	ate	31. Date filed (Month, Day, Year)	2. Registrar's	s Signature		., Dominiore, W			
Regis		JUN 3 0 2009	Peners	B. 16	arkel		•		

DHMH 17 Rev 1/2001 OCME 2006

06-25-2009 **Physician** Rita Lucy Martoche /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 07–29–1930 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Min. 1 □ M 2√□ F Months Days Hours 212-28-6350 78 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a, State 28a-f show Director MD Harford Bel Air 10e. Street and Hazel Nut Ct. 10g. Citizen of What Country? 10f. Zip Code ō 100 G Hazel 21015 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. rmed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Title Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominic Liberatore Ida Molinari 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trauonce. Mary Sasscer (Daughter) 4161 Brittany Drive Ellicott City, MD 21043 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 06-29-2009 Hickory, MD 4 ☐ Donation 5 ☐ Other (Specify) Ignatius Cem. 21. Signature of Funeral Service Lig 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Small Von disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of):

1 - State Registrar

1. Decedent's Name (First, Middle, Lest)

To the Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Physician/Medical

þ

Completed

Medical Certification: To Be

29b. Signature and title of certifie

31. Date filed (Month. Day. Year)

30

F FEMALE: 23b. Was decedent pregnant in the past 12 months?  1   Yes   2   10   9   Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
art II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.

	23e. Did tobacco use contribute to the cause of death?					
	1 □ Yes 2	No 3 Probably 4 Unknown				
	24a. Was an autopsy performed? 1 □ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No				
ath_(	Check only one)					
Home	e 5 ☐ Residence 6	Other (Specify) WSP14				
28	d. Describe how injury					

29d. Date signed (Month, Day, Year)

N. Clarks ST TONSONM)

23d. Date of delivery

Month

20859

3. Time of Death

416A

Birthplace (State or Foreign Country)
 MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

4cms

Year

1 ☐ Yes 2√☐ No

Reg. No.

Vear

Baltimore

14. Race - American Indian.

Mortgage Title Co.

Specify: White

4c. County of Death

USA

2. Date of Death

		1 ∐Yes 2 Mo 1 L Yes 2 L No
25. Was case referred to medical	26. Place of De	eath (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing	Home 5 Residence 6 DOther (Specify) WSP(4
27. Manner of Death  1 → Natural 5 ☐ Pending 2 ☐ Accident investigat		28d. Describe how injury occurred
3 Suicide 6 Could no 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and placaminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Sta	te
Registr	ar

M UES 60701

and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 06-24-2009 Day Charlotte C. Mosko 130 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 Lexington Rd Bel Air Harford Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-14-1924 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 219-16-4240 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Lexington Rd 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 \_\_Yes 2 \_ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 🕅 Married Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic ex Matthew Kalb Frances Faulstich ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Gauthier (Daughter) 223 E Ring Factory Rd Bel Air, MD 21014 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 06-29-2009 Dundalk, MD 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signatur of Euseral Service Licen Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cuncer -/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Medical Certification: To 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of revamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUBRONIA

615

32. Registrar's

W. Marshail Rd Bel Air

29d. Date signed (Month, Day, Year)

Jacqueline Annielia Manelli State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 23, 2009 0912 hrs Medical Examiner Jacqueline Anielia Manelli 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 505 Congress Avenue Apt 509 Havre de Grace Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days oreign Months Hours 01/14/1936 Director 219-34-1911 73 Country) M 2XXF Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Harford Havre De Grace 1 X Yes 2 No 28a-f show or items 23a or 28a-f shomust be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Congress Ave., APT 21078 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes White Yes 2 XXNo specify: 4 XXDivorced If Yes, Give Year Specify Widowed event, the Medical Examiner item 27 is marked other than "natural", ⋧ Pages 1 and 2 should be filed within 72 hours and Pages 1 and 2 should Hygiene 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Barwroski Anelia Garvezki Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa E. Young / Daughter 8553 Ramort Ave., Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State it: If it Burial 2 XXCremation 3 Removal from State W. Arundel Crematory 06/27/2009 Odenton, MD ment c Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licensee Rendon-Bailey Funeral Home, PA M01452 2818 E. Baltimore St., Baltimore, MD 21224 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease complicating hyperthermia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical X AMENDED 23a,27,28a-f,perME, g895 9/29/09 TT UNPENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 V No 9 Unknown g Unknown the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? Yes 2 ✔ No 2 No Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes funeral After t 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Subject 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? exposed to high environmental Yes 2X No Pending To the Funeral Director: completely filled in by the Fd 6/23/09 Fd 9:00 am temperature 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 505 Congress Ave 3 Suicide Could not be or Town, State) 505 Congress A determined (Specify) Homicide home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 25, 2009 and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 28, 5:00 p. 2009 Gerald Frank Martin June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Months Days Director Feb. 8, 1949 60 Maryland 213-52-7482 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Presion Examinar must be inclined at ounce. 10a. State Director 1 ☐ Yes 2√☐ No Harford Maryland Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2713 Rocks Road 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker Credit Union 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Granville Martin Bertha Gav Childers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis F. Martin / Wife 2713 Rocks Rd., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-30-09 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licenses 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Hypoxic Respiratory day Due to (or as a consequence of): Examiner Use to (or as a consequence of): Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 73 months metastatic Lung Cancer Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify). 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Leucocytosis Diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? insubtriciona autopsy performed 2 11No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) cal Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Physician** /Medical 4 6/28/09 P.0. Division of Vital Records, Hospital

physician s the burial

signed by the a d be detached for

page 2 should peen

After this certificate

within 24 hours after useur..
To the Funeral Director: Aft

Baltimore, Maryland 21215-0036

or Attending Physician:

State

Registrar DHMH 17 Rev 1/2001

JUN 30

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KAMAL BANGORZA

Kamal Bangsaia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 32 Registrar's Signature

UPPER CHESAPEAKE MEDICAL CENTER

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0065641

500 UPPER CHESAPEAKE

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** BRYCE DONOVAN MERRICK 2009 12:47p 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Greater Baltimore Medical
5. Social Security Number 6. Sex 7. Age (In vrs Baltimore
If Under 1 Year | If Under 24 Hrs. Ctr Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1⊠M 2□ F Months Hours Director 53 infant 6/15/2009 USA -maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show Brianna ir than "natural", or items 23a or 28a-f show 1 TyYes 2 No Directo MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3819 MONTEREY ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. BLACK ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than eny Injury or other treitments. Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ **BERNARD** DAMIEN MERRICK BRIANNA LYNN TISDALE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore, Medical Ctr 6701 N. Charles Street Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 DOther (Specify) in state 21. Sign ture of ameral Service Licens State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Immediate Cau (Final disease or condition resulting in death) **Physician** Extreme /Medical Due to (or as a consequence of) Examiner pon tane Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or) and Due to (or as a consequence of): physician a s the burial-Physician/Medical attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day signed by the a 5 Other (specify) 2 No ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral dire 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physicien: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, To the

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MARGARET A. CYZESKI, M.D.

Registrar

DHMH 17 Rev 1/2001

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un

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1000

,6565 N.Charles Street, #406, Baltimore, MD

29d. Date signed (Month, Day, Year)

09-03907 W

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Physician Medical		failure List only one cause	on each line.			-	y, sucii as ca	il diac of it	espiratory arr	est, shock	, or near		veen Onset and Death
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Division of Vital Records, at or Attending Physician: The law requing safer death.  al Director: After this certificate has been signed in by the funeral director, page 2 should the state of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the safe of the saf		27. Manner of Death  1 ✓ Natural 5 Pen	28a. Date (Month	e of Injury h, Day,Year)	28b. Time of I		jury at Work?		Bd. Describe	how injury	occurred		
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Stat Registra		31. Date filed (Month, Day, Year)		egistrar's Signat	a park								
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DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 Pay 3:40P M 2009 **Physician** June Nancy McAleer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dundalk 2747 Dunglen Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2X F Director 1-28-1968 MD 215-90-8333 Usual Residence of Decedent t0d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 28a-f show notified at 1 X Yes 2 □ No Director Baltimore Dundalk MD the 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ms 23a or 2747 Dunglen Court 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No White Specify: 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than 'r traumatic event, the Ma than Elementary/Secondary (0-12) College (1-4or 5+) Shopper's Grocery Floor Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည George McAleer Frances McAleer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2747 Dunglen Ct., Jennifer Kuiken-Daughter Dundalk. MD 21222 item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition of permit. Pages Department of Important: If it any Injury or c once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7-3-09 Baltimore, MD Bayview Crematory 22. Name end Address of Facility 21. Signature of Fineral Se Bradley-Ashton FuneralHome PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) [Near] relientue year **Physician** Cance-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 SNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl performed? autopsy 1 ☐ Yes 2₽No 24 hours after death.

Funeral Director: After this certificelely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suîcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a, Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated Medical To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifier 29c. License number 30. Name and address of person who complete death (Item 23a) (Type, Print) MILMERL TERMENT AVE UR 12-11 418VM 4940 Registrar's Signature 31. Date filed (Month, Day, 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** Arline L. Mascetti June 28<sup>ay</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Middle River 514 Nollmeyer Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Days Year June 15, 1937 214-38-2564 1 □ M 2 □ MF PA 72 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Even instructional barrotthed at Middle River 1 ☐ Yes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 514 Nollmeyer Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ∐Yes 2 ∭No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ... 1 and 2 should be of Health and M Kathleed Ensminger John W. Shultz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 514 Nollmeyer Road Baltimore MD 21220 John Mascetti /husband permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, State Date 20a. Method of Disposition Rossville MD 7/1/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 No 5 ☐ Other (specify) 4 Pregnant at time of death □Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 3 Suicide 6 Could not be determined

**Examiner** attending physician and for use as the burial-tran Box 68760, signed by the ad be detached for P.0. Division of Vital Records, Physician: After this or Attending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fun

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated. 29b. Signature and title of certifier

124356

ause of death (Item 23a) (Type, Print)

Square Dr. Ballimore MD

State Registrar

Medical

31. Date filed (Month

	1	For State of Maryla  State Registrar	nd / Depa <i>Cer</i>	artment of Hertificate of D	ealth and M Death	R	eg. No.	) (19	208	867
Physicia	-	Decedent's Name (First, Middle, Last)  Grace Mitchell	Mills			2. Date of Deat Month June	Day 20,	09 Year	3. Time of 7:30	A M
/Medica	1	a. Facility Name (If not institution, give street and number)	111111	4b. City, Town, or	Location of Death			ty of Death		
Examine		Montgomery Hospice Casey House	2	Rockv				gomer		or Foreign
Funeral		. Social Security Number 6. Sex 7. Age (In year)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day September	20, 1922	9. Birthp Cour Conn	olace (State ontry) ecticu	
Director		Javal Residence of Decedent							I0d. Inside C	ity Limits
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a-f st	cto	Maryland Montgomery	Chevy				10g. Citizen o	of What Cour	ntry?	
or 28	Director	De. Street and Number		10f. Zip Code	)815		United			
ath w		8100 Connecticut Avenue	U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		ace - Ameri lack, White,	can Indian,	
filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland theyene. Saa or 28a-f show ther than "natural", or items 23a or 28a-f show ent, the Madical Examiner must be routiled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever if Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	Hican, etc.)	Spec		hite	
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ifiled I Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam			iame)		
Menta Menta Merked arked atic ev	일	Raymond A. Mitchell	401- 14-11	ling Address (Street	Grace			wn, State, Z	ip Code)	
d 2 sho d 2 sho th and 7 is ma traum		19a. Informant's Name/Relationship (Type. Print) Pamela Mills Brancaccio/Daught	ter 3718	Cardiff I	Road, Che	vy Chas	e, Mar	yland	20815	
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viruit. Pages apartment of aportant: If it ny injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  M0130		22 Name and Address Obert A. Pui	ess of Facility	ral Home/	Rockvil	le, Inc		
<b>a</b> 88 <b>a</b> 8		23a. Part1. Iter In e disease, or complications that caused the shock or heart failure. List only one cause on each line.	death. Do not e	nter the mode of dyi	ng, such as cardia	c or respiratory	arrest,	en y rang	Approxim Interval B Onset and	iate Between
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as # @	Physician/Med	IF FEMALE: 23c. If yes, outcome of p 23c. Was decedent pregnant 1 □ Live birth 2 □	Fetal death	3 Ectopic pregnar	псу		23d	I. Date of de Month	livery Day	Year
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nysici hysici his ce I direc		1 ☐ Yes 2 🛣 No ☐ Hospital. 1 ☐ Inpatient	2 ER/Outpa	itient 3 🗆 DOA		Home 5 ☐ Re	esidence 6 £ e how injury c		ecify) 1103	spice
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Division of Vital Records, if or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be or a fine by the funeral director, page 2 should be or a fine by the funeral director.	Certification: To	2 Accident 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc. (	- At home, farm, Specify)			28f. Location City or 7	(Street and I own, State)	Number or F	Rural Route I	Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 8	Medical Ce	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of reach and manner stated and manner stated	camination and/c	leath occurred at the or investigation, in m	e time, date and pla y opinion, death oc	ace, and due to t				
o the vithin 2 o the	Med	29b. Signature and title of certifier	.\		ense number	8			nth, Day, Yea	ar)
		J. Kencetchen, m.			5374	8	June	20,		
15 V		30. Name and address of person who completed cause of dear Jocelyne T. Kouatchou, M.D.	6001 M	uncaster	Mill Road	d, Rocky	ville,	Maryl	and 20	)855
	tate	31. Date filed (Month, Day, Year)  32. Registrar's	Signature	an Kal						
Regis		31. Date filed (Month, Day, Year)  JUN 3 0 2009  Registrar's	p. 19							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ye ar **Physician** George L. Miller 2:21 4 M 06 29 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A If Under 24 Hrs 8. Date of Birth May 19, 1935 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □XM 2 □ F Months Days Hours Min. 74 Mary Tand 216-30-0972 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at Baltimore N/A Maryland Funeral Director 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LISA 21214 5613 Birchwood Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 XIYes 2 □ No 1952If Yes, Give 1960 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 X Yes 2 □ N If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Steelworker Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental Edith Stiffler Leroy W. Truckermiller ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 9328 Shadycreek Way Baltimore Maryland 21234 Department of Health Important: If item 27 any Injury or other troope. Edward L. Miller/Son timore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ţ 1 → Burial 2 □ Cremation 3 □ Removal from State Glen Burnie Marvland Glen Haven Memorial Park 7/2/09 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service License huste 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3 weeks obstructive pneumonia Sequentially list conditions, if any least sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed unknown Metastatic cancer and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, 2 hours Physician/Medical myocardia IF FEMALE: for use 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ tenal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 🗷 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1∐ Yes 2. 🗹 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 □Yes 2 □No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D 000 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Loch Raven Blvd 5601

State

Registrar

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Good Samaritan

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JUN 3 0 **200**9

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Month **Physician** 2009 2:45 A M Earl M. Monroe, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ñ/Ä Baltimore 3302 Norman Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 11–29–1934 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Hours Min. 1 M 2 □ F Maryland 74 213-32-1980 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show or than "natural", or items 23a or 28a-f show the Madical Exemples in the Madical Exemples in the motified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3302 Norman Avenue 21213 U.S.A. death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 DYes 2 No 1957– If Yes, Give 1965 Year or Dates: 1965 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Western Electric Accountant is marked other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If item 27 is marked other any Injury or other the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contrac 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl M. Monroe, Sr ပ Regina Aut 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Patricia Monroe - Wife 3302 Norman Avenue Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/29/2009 Parkwood Cemetery Baltimore, Maryland 4 Denation 5 ☐ Other (Specify) 21. Signatur of Fun ral service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 M /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate tal or Attending Physician: Thes after death.

In Director: After this certificate ed in by the funeral director, pag 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records,

Box 68760

P.0.

the Hospital the

DY

Funeral D etely filled in

npletely

Medical

24 hours

GREGORY L. WALKER 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

*JUN* 3 0 2009

STE 540 -Johnson Bldg. Registrar's Signatu

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Baltimore MD 21218

29d. Date signed (Month, Day, Year) 26

2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:58 PM Baby Boy Nana /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Paitimor HOPKINS 8. Date of Birth (Month, Day, Yea June 11, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Year) 2009 **Funeral** Days Maryland 1 X M 2 □ F Yrs infant Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State MD 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at Montgomery Burtonsville 1 ☐Yes 2√ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3625 Silver Spruce Circle 20866 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∏Yes 2 ∏ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: black Specify: ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+)
infant infant infant Department of Health and Mental Hygie Important: If item 27 is marked other tany injury or other traumatic event, In once. 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be should be 1 Patricia Nana ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) The Johns Hopkins Hospital 6001 N. Wolfe Street Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Spesify) in state 21. Sign rure of transal Sar ce Lice 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Direk Wade, Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 28a. Part 1. shock, Immediate Ca Final disease or condition resulting in death) Physician extreme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to for an a nonequirenes of Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy
□ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autonsy performed? certificate 1 ☐Yes 2 No 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (C eck only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 🗋 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide (x) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Records, Division of Vital n 24 hours after death.

le Funeral Director: Aff within 2.

> State Registrar

29b. Signature and title of of tifier

30. Name and address of power with

Kimberty
31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

and manner stated.

Levinson

Year)

completed cause death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

Res-000

600 North Wolfe Street Baltimore Maryland 21287

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** naalien 12:30P M DONS 26, 2009 June /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X Director 217-26-0340 8-7-1930 78 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Evantrer must be notified at 1 Xes 2 No Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3405 Leverton Avenue 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medie once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard J. Saukites Helen Hartzell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Naglieri - Son 3405 Leverton Avenue, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery: 6-30-09 Baltimore, MD 22. Name end Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licenses WHite Ket PA, 2134 Willow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rulmonary **Physician** embolism /Medical Due to (or as a consequence of): Examiner pulmona Sequentially liet on diffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed sician and burial-trans FNACTIVI Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy After this certificate 1 □ Yes 2 🔀 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 NER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: 2 the Hospital

> State Registrar

cal

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. macDonald

29a. Certifie

thudson

2801

32. Registrar's Signature

1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

STYPET

29d. Date signed (Month, Day, Year)

Ballo and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2000 Edward G. Nocar 5 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Kosedale If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours t**y** M 2□ F 212-42-5105 Director 66 April6,1943 MD Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, I've Medical Examinat must be multified at Baltimore Middle River 1 □Yes 2 No MD Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21220 808 Frog Mortar Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examinations. Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio Specify White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood Salesman Owner 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marquerite A. Wagner George A. Nocar ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
808 Frog Mortar Road Baltimore MD 21220 19a. Informant's Name/Relationship (Type. Print) Christina V. Nocar /wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/1/09 OAk Lawn Cemetery Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wire of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 / Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier D006474 6/27/09. VASILADOMS

State Registrar

Itimore,

Division of Vital Records, P.O. Box 68760

are Drive Baltimore, MD

Franklin Squ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasiliade

JUN 30

31. Date filed (Month, Day, Year)

09-04597 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edmund Odoms State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day June 9, 2009 Medical Examiner Edmund Odoms 1715 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number unk 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Director Months Days Hours 49 Nov 21, 1959 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 123 N. Broadway Street 21213 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. unk Yes Specify: black Yes 2 X No specify: Widowed Divorced If Yes, Give Year ģ UBBIG 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work do 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) unk unk 18.Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in stat 21. Si ature of Fun ral Servi Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interva failure. List only one cause on each line Between Onset and /Medical Death Immediate Cassa (Final disease Cardiac arrhythmia Examiner or condition resulting in death) Due to (or as a consequence of) Increased cardiac fibrosis Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran Physician/Medical XUNPENDED AMENDED PI line a-b, PII, 27, per ME g894 8/25/09 TT To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Functan Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? \$ Liver cirrhosis Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 ✓ Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

OCME

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who complet a cause of death (Item 23a)

29b. Signature and title of certifier

Melissa Brassell, MD

32. Registrar's Signature

Assistant Medical Examiner

and manner stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Carmela Platania 27 June 2009 12:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 2706 Burridge Road Parkville
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M & X Months 212-46-3192 Yrs 63 Jan. 14, 1946 Italy Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Exercitors aust be notified at 1 □Yes 2₩ Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2706 Burridge Road Funeral 21234 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2**√2)** If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or þ 1 ☐ Yes 2√√No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Beautician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Sant'Antonio Biagio DiNatale ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21234 Health em 27 i Frank Platania-spouse 2706 Burridge Road-Parkville, Maryland permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery July 1,2009 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES 8800 Harford Road 21234 Parkville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** YRS. ADVANCED ALZHEIMER'S DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any lead in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Physician: The law requires that the death certificate be executed and physician a s the burial-1 Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending phiched for use as the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached for ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2XNo 24a. Was an page 2 s has autopsy performed? certificate 2**X** No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2/2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 X Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie June 29, 2009 M . D . D0017728 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21236 8022 Belair Rd. Ounq, Ва Yin 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 12:41 DM 25 2009 a JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES 1ATIG2OH BALTIMORE St If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 □ M 2 💢 F 213-52-0565 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Model Exmitten in usits a notified at once. 10a State 10b. County 10c. City, Town or Location t Ses 2 No by Funeral Director timore 10g. Citizen of What Country? 10e Street and Number 21229 dmondson 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Baltimore, Maryland (Eirst, Middle, Last) Be de DIXON Emma ပ 19b. Mailing Addjess (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's name/Relationship (Type. Print) - Wilson Daughter 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Services Baltimore Nat'I 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAY Immediate Cause (Final disease or condition resulting in death) EMBOLLSM **Physician** DULMONARY BILATERAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for se a consecuence off Examiner Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical attending ph d for use as th 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ned by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION DIABETES certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🖪 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P 23748 M.D JUNE, 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD-21229 RAJANI JAGANA, St. AGNES HOSPITAL, 900 SOUTH CATON AVENUE. 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - Stata Registrar	State of Mar	•	artment of F			Reg. No.		20876
	Physici /Medic		Decedent's Name (First, Middle, Last)     William J. Pipe:					2. Date of De June 2	5, Day 2009	Year 1:	15 P. M
,	Examin		4a. Facility Name (If not institution, give st Manor Care Falls R	oad			imore			I/A	
	Funeral Director		5. Social Security Number 217-07-4768  Usual Residence of Decedent	M 2□F 7. Age (	In yrs. last birthday Yrs.	If Under 1 Year   Months   Days		May 13,	<sup>10</sup> 1918	9. Birthplace (S Country) Marylan	nd
	e Maryland e-f ehow	ctor	10a. State 10b. County Maryland N/A	1	Oc. City, Town or L Bal	ocation timore				XX	ide City Limits ☐Yes 2 ☐ No
Z1Z15-UU36 d within 72 bours offer death with the Manyland	th with the 23e or 28	al Director	10e. Street and Number 3342 Chestnut Aven	ue		10f. Zip Code 2	1211		10g. Citizen of W USA		
	be filed within 72 hours after death with the Marylan tal Hygtiene. ad other than "natural", or Items 23s or 28s-1 show of other than "natural" franciscal Examiner mast be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	<ol> <li>Was Decedent Ev Armed Forces?</li> <li>Mary Yes 2 □ No If Yes, Give Year or Dates:</li> </ol>	er in U.S. 13	Was Decedent of H tf Yes, specify Cub 1 ☐ Yes ※ No	dispanic Origin an, Mexican, P Specify:	? (Specify Yes or No Luerto Rican, etc.)	ecify Yes or No- Rican, etc.)  14. Race - American Black, White, etc.  Specify: Whit		
	d within 72 h piene. r than "natu Ine Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retire ne Operat	during most of d)		16b. Kind of Bus		
<u> </u>	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) William John Piper					Name (First, Middle Crabs	, Maiden Surname	a)	
, mary	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evance.		19a. Informant's Name/Relationship (Type Winifred Roach	Daughter		4140 Fal		or Rural Route Numb	re, Mary	land 21	211
Baltimore,	Pages 1 tment of H tant: If iter ijury or oth		20a. Method of Disposition  1XX96urial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		Druid R	idge Ceme	etery 6,		20c. Location - 0	le, Mar	ryland
g D	Depar Impor any ir		21. Signature of Funeral Service License	· Hen	3 B	urgee-Hen 631 Falls	ss-Seit Road,	z Funeral Baltimore	Home, I Maryla	nc. 212	211
	Pnysician /Medical		23a. Parī . Enter/he disease, or complic shock, or heart failure. List only one Immediate Cause (Finat disease or condition resulting in death)	e cause on each line		S CV D	ng, such as ca	rdiac or respiratory a	rrest,	Interv	oximate val Between of and Death
,160,	e be executed sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dreade of Iriju.) that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								
O. Box 68	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medi							23d. Date Mor	e of delivery hth Day	Year
rds, P.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions conf	tributing to death but	not resulting in the	underlying cause gr	ven in Part I.		tobacco use contr Yes 2 □ No	ibute to the cau 3	
II Kecords,		Completed						24a. Was auto perfe 1 🗆 Yes	psy prmed? p	Vere autopsy fir rior to completic eath?	on of cause of
or Vital	Physician: this certific ral director,	To Be	I Tes No	ospital: 1  Inpatient	100	ent 3 DQA	her: Nursi	Death (Check onlying Home 5 🗆 Res	dence 6 □Othe		
DIVISION (	tending leath. tor: After the fune	Certification;	27. May r of Death  Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		Wo M 1□	]Yes 2□No		how injury occurre		to Number
<u>≥</u>	ne Hospital or Atten n 24 hours after deat ne Funeral Director: bletely filled in by the		4 Homicide determined			street, factory, office		City or To	wn, State)		e rumber,
	To the Hosp within 24 ho To the Func completely f	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	er: On the basis of e and manner state	xamination and/or	investigation, in my	opinion, death	occurred at the time,	date and place, a	and due to the c	Vanel
	Vit To		29b. Signature and title of certifier			D5	7723	voods	6/26	109	/
			30. Name and address of person who con	navo	8813	Wall?	com 1	Noods	God.	MD 21	1234
	Sta Regist		31. Date filed (Month, Day, Year)  WN 3 0 2009	32. Registrar	Signature						

# Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Expansion resist be retified at once.

Physicia /Medica Examine

Funeral Director

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

/Medical Examiner

1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day  William Charles Powers Jr  June 20,	11114 / 118 /									
William Charles Powers Jr June 20,	3. Time of Death									
	2009 5:09 A M									
4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Cou	unty of Death									
Greater Baltimore Medical Center Towson B	Baltimore									
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)									
213-26-9361   1 <sup>1</sup> X M 2 G F   77 Yrs.   Months   Days   Hours   Min.   Dec 16, 1931	Maryland									
Usual Residence of Decedent										
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
§ MD Carroll Sykesville	1 □Yes 2√ No									
10e. Street and Number 10f. Zip Code 10g. Citizen	of What Country?									
5855 Springmount Court 21784 US	A									
	Race - American Indian,									
1 Never Married 2 Married 1 Yes 2 XNo	Black, White, etc.									
3 ☐ Wildowed 4 ☑ Divorced If Yes, Give Year or Dates:	ecify: white									
3 Wildowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12 Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify	of Business/Industry									
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master plumber pl	umbing									
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sun	name)									
William Charles Powers Sr Julia McDonald										
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To	wn, State, Zip Code)									
Judith Boyle/daughter 5855 Springmount Court Sykesville,	MD 21784									
20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition (Name of Disposition Date Date Date Date Date Date Date Date	on - City or Town, State									
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Sequity)										
21. Signature of Experies Licensee Rolling Rolling State Anatomy Board 655 W. Baltimore Street  Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rolling Rollin										
3a. Part 1. Inter the disea has a complication of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate									
shock, a heart failure. List only one cause on each line.	Interval Between Onset and Death									
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Due to (or as a consequence of):	F -									
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that initiated events resulting in death) Last  C										
d										
IF FEMALE;										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 24d. If yes, outcome of pregnancy 24d. If yes,	Date of delivery									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Date of delivery Month Day Year									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Month Day Year									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Month Day Year contribute to the cause of death?									
FFEMALE: 23b. Was decedent pregnant in the past 12 months?	Month Day Year									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 5   Other (specify)   Pregnant at time of death 5   Other (specify)   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnant at time of death 3   Ectopic pregnancy 2   23d.   The pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 2   23d.   The pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic pregnancy 3   Ectopic	Month Day Year  contribute to the cause of death?  to 3 Probably 4 Unknown  4b. Were autopsy findings available									
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d.   Fetal death 3   Detection   23d.   Pregnant at time of death 5   Other (specify)   Part II.   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use of the underlying cause given in Part I.   23e. Did tobacco use of the underlying cause given in Part I.   24e. Was an autopsy performed?   1   Yes 2   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   No.   N	Month Day Year  contribute to the cause of death?  lo 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?									
23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1	Month Day Year  contribute to the cause of death?  10 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of									
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23c. If yes, outcome of pregnancy   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.	Month Day Year  contribute to the cause of death?  lo 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No									
23c. If yes, outcome of pregnancy   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.	Month Day Year  contribute to the cause of death?  To 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No  Other (Specify)									
23c. If yes, outcome of pregnancy   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.   23d.	Month Day Year  contribute to the cause of death?  To 3 Probably 4 Unknown  Ab. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No  Other (Specify)  courred  umber or Rural Route Number,									
23d.   If FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Month Day Year  contribute to the cause of death?  10 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 UYes 2 No  1 Other (Specify)  courred  umber or Rural Route Number,									
23d.   If FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Month Day Year  contribute to the cause of death?  10 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 UYes 2 No  1 Other (Specify)  courred  umber or Rural Route Number,									
23d.   If FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Month Day Year  contribute to the cause of death?  10 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 UYes 2 No  1 Other (Specify)  courred  umber or Rural Route Number,									
23d.   If FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Month Day Year  contribute to the cause of death?  10 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 UYes 2 No  1 Other (Specify)  courred  umber or Rural Route Number,									
23c. If yes, outcome of pregnancy in the past 12 months? 1	Month Day Year  contribute to the cause of death?  10 3 Probably 4 Unknown  4b. Were autopsy findings available prior to completion of cause of death?  1 UYes 2 No  1 Other (Specify)  courred  umber or Rural Route Number,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25 Day 2009 2:45P M Joyce Elaine Powell June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Examiner Baltimore MAnor Care / Rossville 8. Date of Birth (Month, Day May 21, 1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 215-55-4243 1 □ M 2 12 F 84 Director Jamaica Usual Residence of Decedent 10b. County 10d. Inside City Limits show 10a, State 10c. City. Town or Location event, the Medical Examiner must be notified at Director Middle River 1 ☐ Yes 2 ☐ No Baltimore MD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò filed within 72 hours after death with 21220 2167 Redthorne Road 23a USA Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married ٥, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: Specify. Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker own home permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other 1 any Injury or other traumatic event. 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruben Blanchard Edna Dillion ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Ward /daughter 2167 Redthorne Road Baltimore MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6/26/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC ADENO CARCINOMA disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Year Day 5 ☐ Other (specify) signed by the a P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ¶☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy perform 2 🔽 2 No 1 □Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 🗌 No the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely

State Registrar 29h. Signature and title of certifier

PANICAT

31. Date filed (Month.

IMY

9106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rec

144ETERPAI

29c. License number

D0060570

PHILADELPHIA RD. #208,

29d. Date signed (Month, Day, Year)

BALTIMONE

W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month <sup>Day</sup> 2009 Mary Lee 12:30 Ouinn 28, June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 😡 F 220-05-2262 Director 89 Jan. 31, 1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, inc Medical Examinations to molified at MD Baltimore Parkville Director 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Broadview Terr.1115 21234 Be Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □ No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Printing Company 12 Pages 1 and 2 should be filed vent of Health and Mental Hygident. If item 27 is marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Michael Bergman Mary Thim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Quinn-son 243 Bentley Road-Parkton, Maryland 21120 Department of Healt Important: If item 2: any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery July 2,2009 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES 8800 Harford Road Parkville,MD 21234 Condine home foods 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRAVENTRICULAR HEMDRRAGE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) attending physician certificate be Physician/Medical Box ( IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant that the death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month 5 Other (specify) o. 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ś the Hospital or Attending Physiclan: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Funeral 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Watther Glvd. Batto MD

s CRIT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [] S Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 91 00 AM 2009 arroll 25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1107 Wicklow Rd. Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F 74 Director 213-30-3553 04/01/1935 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinar must be notified at No Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1107 Wicklow Rd. 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2★ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black 2 3 ₩ Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Specializing Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver In Leasing 12th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aaron Rhodes ဂ္ Irene Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Rhodes/ Daughter 1107 Wicklow Rd.Baltimore, MD, 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department of Important: If any Injury or once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 06/26/09 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service License 638 N. Gilmor St.Balto., MD, 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Meldsta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4. Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

821 NEala A. AHMED 5 31. Date filed Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year US **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SACTIONDEE N/AUS TVA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 □ F Months Days Min. 157-24-7922 PENNSYLVANIA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 610 N. CALVERT STREET APT.D 21202 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: WHITE ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY GENERAL ELECTRIC CO. 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE SUPLEE VIOLET CRICHTON ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a NORMAN REVIS/ HUSBAND Department of Health Important: If item 27 any injury or other trong. 610 N. CALVERT ST., APT. D, BALTIMORE, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 6/27/09 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 21N Physician to disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Ye ar 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 □Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after decral Director: Aft 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Medical

Division of Vital Records, P.O. Box 68760 within 2

t certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

e and address of person who completed cause of death (Item 23a) (Type, Print)

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>009 June 29, 5:30 A M Anna Jeannette Raines 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Towson Pickersaill Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Months Days Hours 3/16/1908 Mary land 1 □ M 2 😿 F 101 217-24-6599 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County

10f. Zip Code

21204

1 ☐ Yes 2**XX**No

16a. Decedent's Usual Occupation

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Serv. Corp.

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Ruck Towson Funeral Home,

(Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

Towson

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

Tavlor

28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notifiled at death with Pages 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Ms once.

**Physician** 

/Medical

Examiner

10a, State

MD

10e Street and Number

1 ☐ Never Married 2 ☐ Married

3 ☑ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

21. Signature of Funeral Service License

Louis

John M. Raines, Jr. / Son

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

12

11 Marital Status

Marshall

20a. Method of Disposition

Director

Funeral

þ

Completed

Be

Baltimore

15. Decedent's Education (Specify only highest grade completed)

615 Chestnut Ave. Apt 1210

**Funeral** 

Director

Physician /Medical Examiner

Hospital or Attending Physician; The law requires that the death certificate be execut burial-tran Division or Vital Records, P.O. Box 68760,爻 physician the as for use signed by the a page 2 s funeral director, this After

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) debi 12 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Be Completed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier within 24 ho

To the Function

completely 1 (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 N. Charles St. Balto Ind 21208

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 1□ Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 X No

months

10g. Citizen of What Country?

16b. Kind of Business/Industry

20c. Location - City or Town, State

Towson, Maryland

Maryland 21204 Inc. 1050 York Road

14. Race - American Indian,

White

Black, White, etc.

USA

Dwn Home

18. Mother's Name (First, Middle, Maiden Surname)

Towson,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7980 Mackintosh Dale Glen Burnie, MD 21061

7/3/2009

Date

Katherine Julie Matthews

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 19a, per Fh g892 6/30/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 ay 11:25 AM **Physician** BRONIA ROTHOLZ Lupe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE KESWICK MULTI-CARE CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) LITHUANIA **Funeral** Hours (Month, Day, Year) 02/01/1926 Months Days Min. 1 □ M 2 💢 F 214-15-1761 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 X Yes 2 □ No **Funeral Director** MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o e 2901 FALLSTAFF ROAD, #505 21209 USA ms 23a death . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 🛣 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 Is marked other than ' r traumatic event, the Me. Elementary/Secondary (0-12) 12 College (1-4or 5+) OWN HOME **HOMEMAKER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HERSCHEL KUR SARA BURIN YANKEL ပ 19a. Informant's Name/Relationship (Type. Print)
- METLAH ROTHOLZ / HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 FALLSTAFF ROAD, #505, BALTIMORE, MD 21209 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 X Burial 2 □ Cremation 3 □ Removal from State ARLINGTON CHIZUK AMUNO 06/29/2009 BALTIMORE, MD 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Confirmaleration Cardinascular disease Years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dual to for self-econecusines of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Clearendenin 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Vithin 24 hours and To the Funeral Dir l 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar MISABELLE

31. Date filed (Month, Day, Year)

JUN 3 0 2009

DHMH 17 Rev 1/2001

700W. 40th STREET, BALTINGRE, MO 21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MARGO EGOR

Tune 28, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6:24 PM 28 60 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Maryland University Baltimore 01 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex<sup>€</sup> 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 □ M 2 X F Months Days Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Yes 2 ☐ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black ?7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lerica 17. Father's Name (First, Middle, Last) Be ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Greene Funeral Services 21. Signature of Fungral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Massive Physician hemonhave medistino. /Medical Due to (or as a consequence of), Examiner aprili Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 75 centurg Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, physician Physician/Medical as attending | for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year 5 Other (specify) ed by the 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate mnedr? 2 **K** No 2 🗆 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending ours after death.

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filled in by the fu death. investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6810+

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who con



cause of death (Item 23a) (Type, Print)

21201

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8&18 Per FH 6&9 of Mary 600 / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200<sup>Ye ar</sup> Physician 25, June 11:16 PM Evelyn L. Schreyer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Dove House Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M **X**X F 83 25,1925 Pennsylvania Director 211-18-1585 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location tems 23a or 28a-f show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes XXNo Director MD Carrol1 New Windsor 10g. Citizen of What Country? 10e Street and Number 21776 U.S.A. P. O. Box 471 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 □Yes **XX**No If Yes, Give Year or Dates: Specify: Specify: ģ White XXWidowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) איים Mental Hygiene. 127 is marked other than "ר. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental (Heeter) ∀ida Raymond A. Zeak ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health an Important: If Item 27 is any injury or other trau 3327 Carroll Ave. Owings Mills, MD 21117 R. Joseph Schreyer, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State July 6, 2009 Owings mills, MD 5 Other (Specify) Veterans Cemetery | Oury O, 2000 | 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 4 ☐ Donation 21. Signature of Fine IS ice Licensee was 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Lich line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto for as a nonsequence off-The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical as attending IF FEMALE Se 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 🗆 Ectopic pregnancy Po Month Day in the past 12 mor Pregnant at time of death 5 Other (specify) 1 ☐ Yes Ö been signed by the should be detached 9 Unknown 9 Unknov ٣. 23e. Did tobacco use contribute to the cause of death? ificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 🗆 No 2[ 1 ☐ Yes 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to examiner? funeral director. Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours t**he Funeral Dire** sty filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) completely To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Center ST 31. Date filed (Month, Day, Year) 32. Registrar's State JUN 3 0 2009 Registrar

Guenzolyn STAINSACK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05092 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0050 hrs June 28, 2009 Gwendolyn Denise Stainback al Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital g. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Country) MD **Funeral** Months Days Hours 12/05/1958 219-74-9455 Director 50 2X F Yrs M Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Baltimore or items 23a or 28a-f show must be notified at once. MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 USA 1419 Bond St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces? 1 XNever Married 2 Married 2XX No Yes Black Specify: Yes 2 X No specify: Yes, Give Year Divorced 3 Widowed Š Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Self-employed Housekeeping MD 21215-0036 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Nixon Junious Stainback 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 4922 Palmer Ave., Baltimore, MD 21215 Harry B. Stainback / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 07/01/2009 Odenton, MD Arundel Crematory Other Specify: Donation 5 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Funeral Service Licensee M01452 2818 E. Baltimore St., Baltimore, MD 21224 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death Medical a. Morphine intoxication Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last transit and 23a, PII, 27, 28a-f, permE, g893 7/22/09 TT Physician/Medical X UNPENDED AMENDED attending physician or use as the burial -To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Vear Month Day 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death I ive birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 V Unknown for g Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown þ Cocaine use; Hypertensive cardiovascular disease Completed 24b. Were autopsy findings available 24a. Was an s peen s prior to completion of cause of death? autopsy performed? To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sl 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 Other DOA Inpatient 2 FR/Outpatient 3 1 Yes မှ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: Yes 2 XNo 1 Natura! Pending death. Fd 2352 Hrs Fd 6/27/09 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1433 N. Bond St Baltimore, MD 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined other (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 28, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year State Registra DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:55 AM 200 simms vaomi iuns /Medical AGNE S (+OSP(TA) 4c. County of Death 4a. Facility Name (If 4b. City. Town, or Location of Death **Examiner** SALIIMORE If Under 24 Hrs. 8. Date of Birth If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 212-40-1836 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County Town or Location if than "natural", or items 23a or 28a-f show 1 ☐Yes 2 ▼No **Funeral Director** ind soc 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 62 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Slack Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) marked other than College (1-4or 5+) ler permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, the Once. Name (First, Midd Be ola 19b. Mailing Address V Street and Number or Rural Route Number City or Town, State, Zip Code) Informant's Name/Relationship (Type. SWW!C reman 20a. Method of Disposition Date Surial 2 ☐ Cremation 3 ☐ Removal from State 1 Burial 2 ☐ Cremauon 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a. Part 1. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ours. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 MOROWS MEPAROTIC **Physician** HTHOM /Medical Due to (or as a consequence of): Examiner LOIDOSIS MKHOWH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) the ☐Yes 2☐No o 9 Unknown signed by σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 ☐ Probably 4 ☐ Unknown 2 🔲 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate Vital 1 □ Yes 1 □Yes To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of this Date of Injury (Month, Day, Year) 27. Manner of eath 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 ☐ Pending investigation Injury 2  $\square$  No 1 □ Yes 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title, 29c. License number JUNE 26 nu 60105 ensa 100 30. Name and aptisess of person who completed cause of death (Item 23a) (Type, Print) AVENUE BALTIMORE ZIZZA CATOM UVIST -1145RSOM 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 3 0 2009 Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Mar	yland / [		rtment of He tificate of D		-	giene Reg. No.	2009	20889
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-	/Medic	al	BERNADETTE M. SCHW 4a. Facility Name (If not institution, give s				4b. City, Town, or L	ocation of Death	June		2009 County of Death	11:00A <sup>M</sup>
17.00	, LXaiiiii	G1	2102 Oaklyn Drive				Fallsto				Harford	
c	Funeral Director		5. Social Security Number  213~26~8117  Usual Residence of Decedent	M 20XF 7. Age (	(In yrs. last bir	thday) Yrs.	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 9,	ay, Year)	9. Birthp Cour Mary	place (State or Foreign htry) land
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventries must be notified at	,	10a. State 10b. County	1	0c. City, Town	n or Loc	cation				1	0d. Inside City Limits
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		I Dir	10e. Street and Number 2102 Oaklyn Drive				10f. Zip Code	1047		-	zen of What Cour SA	ntry?
36	rs after death I", or items 2.	by Funeral Director		2. Was Decedent Eve Armed Forces? 1 ∐Yes XX No If Yes, Give Year or Dates:	er in U.S.		Vas Decedent of His fYes, specify Cuban □Yes 🏋 🔃 No		ecify Yes or No Rican, etc.)	)- 1	4. Race - Americ Black, White, Specify: Whi	etc.
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Mar	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship (Type Gerard Schweiger (		I .		g Address (Street al					Code)
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Baltimore, Maryland 21215-0036	t. Pa rtmer rtant:		1 ☐ Burial X ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Cre	matory,In	c.   6-27	-2009			Maryland
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	Physician /Medical Examiner	ər	23a. Part1. Enter the disase, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  Due to (or as a compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the c	consequence	er of):	er the mode of dying	, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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no	nding tth. '; After e funei	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, )		Injury	Work	es 2 □No	28d. Describe	now injury	y occurred	
Division	To the Hospital or Attending Physician: The I within 24 but outs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		arm, stre	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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	To th withii To th	Me	29b. Signature and title of certifier				29c. License	number			e signed (Month,	Day, Year)
			30. Name and address of person who co	· ·	,		Print)			• (		- ,
	Sta	te	31. Date filed (Month, Day, Year)	32. <b>Jegistra</b> r	S Signature	8 PV	4.1 Kel	our mo				
	Registr		JUN 3 0 200	32. Fegistrar	L. B.	4	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year June Gloria Smuck 3:15A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 383 Centerhill Avenue Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, OCL. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 1 □ M 2 □ F 80 MD 212-26-0427 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 383 Centerhill Avenue 21090 U.S.A. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary N.S.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lipo Elsie Gorecki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Denise Clevinger/Daughter 383 Centerhill Linthicum MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2009 4 Donation 5 Dother (Specify) Brooklyn, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Moj357 Services PA 1 2nd Ave SWGlen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARTERIOSCLEROTIC CARDIO VASCULAR

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "any Injury or other traumatic event, the Propose."

**Physician** 

/Medical

Examiner

10a, State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Funeral Director

Completed by

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

nse 2 Be Completed Medical Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1 Toolston of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	Due to (or as a consequence of):	DE 6183				
Yallille.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c					
		, d					
y sicial prince	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year				
of the man	ATRIAL A	contributing to death but not resulting in the underlying cause given in Part I. BC(ししかて(oル	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dnknown				
21411120	OLD STRO	KE	24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
≀	25. Was case referred to medical examiner?	26. Place of Death	(Check only gne)				
2	1 ☐ Yes 2 🔼 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 P Residence 6 □ Other (Specify)				
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury at Work?  Month, Day, Year) 28b. Time of Injury M 1 □Yes 2 □No	8d. Describe how injury occurred				
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
5	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	hysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated.  ed at the time, date and place, and due to the cause(s)				

29c. License number

21776

29d. Date signed (Month, Day, Year)

PASADENA MD 20122

JUNG 25, 2009

State

31. Date filed (Mo

29b. Signature and title of certifier

8021 RITCHIE YELVY MUNDEAND

MD

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ам Stephen В. Spiers 28, 2009 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 5320 Sweetwater Drive West River Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/02/1949 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 **X**M 2 □ F 60 212-58-0403 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examiter must be rediffed at Anne Arundel West River 1 🕍 es 2 🗆 No MD Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or I arry or other traumatic event, II's Mindical Examiliar must be and or other traumatic event, II's Mindical Examiliar must be and on the present traumatic event. 20778 USA 5320 Sweetwater Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ Food Salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Bonney Emma Henry Spiers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5320 Sweetwater Dr., West River, MD 20778 Spiers / Wife Beatrix permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State 06/29/2009 Hanover, MD Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorota, Marshall 22. Name and Address of Facility
Maryland Cremation Services

MD Pow 1412 Politimers MD U. Marshall PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years **Physician** Multiple Myeloma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or any of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o been signed by the should be detached a 🗆 Haknowa 9 Unknown ۵, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🕍 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 □Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical director Be examiner' Other: 4 \( \text{Nursing Home} \) 5 \( \frac{\text{\$\mathbb{X}}}{\text{Residence}} \) 6 \( \text{Other} \) (Specify) 1 ∐ Yes 2 ∐XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation neral Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
June 29, 2009 29c. License number 29b. Signature and title of certifier D oo42593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashraf Z. Badros 10 V 22 South Greene Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) -

Clever

				artment of Health and Mental I	Hygiene Reg. No. 2009 20892					
	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Month June						
	/Medic	al	Tula Jane Sacilotto  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	24 <sup>ay</sup> 2009 <sup>eat</sup> 3:12p M					
	Examin	er	Riverview Nursing Center	Essex	Baltimore					
Ī	Funeral Director		5. Social Security Number 315—16—7130  6. Sex 1 □ M 2 □ F  90 Yrs.		f Birth 9. Birthplace (State or Foreign Country)					
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits					
	Maryl	tor	MD Baltimore	Essex	1 □ Yes 2√2 No					
	h with the	Funeral Director	10e. Street and Number 351 Montrose Avenue	10f. Zip Code 21221	10g. Citizen of What Country? USA					
36	72 hours after death with the Marylan natural; or items 23a or 28e-f show ited Exit directions to mailted at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ② □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 🗆 Yes 2 🐼 No Specify:	or No. 14. Race - American Indian, Black, White, etc.  Specify: White					
21215-0036	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28e-f ehow the Medical Exardiner front be mailfied at	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) memaker	16b. Kind of Business/Industry  own home					
land 21	filed Hygi ther ent, L	To Be Cor	12th  17. Father's Name (First, Middle, Last)  Oscar Bramlett	18. Mother's Name (First, Mi	iddle, Maiden Sumame)					
Maryland	and 2 should be ealth and Mental n 27 ie marked c ier traumatic eve		1.1.1	ing Address (Street and Number or Rural Route N	umber, City or Town, State, Zip Code) Stewartstown PA 17363					
Baltimore,	permit. Pages 1 and 2 Department of Health s importent: if item 27 to any injury or other tra once.		20a. Method of Disposition 1 □ Sturial 2 □ Cremation 3 □ Removal from State 1 □ Cremation 5 □ Other (Specify)	osition (Name of Date matory or other place) Wn Cemetery 6/29/09	20c. Location City or Town, State Baltimore MD					
Balti	permit. Departminimporte any Inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility 300 MA Connelly Funeral	Ace Ave. Balto. MD Home of Essex 21221					
	Physician	A STATE OF THE PERSON NAMED IN	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac or respirate  Demonda	ory arrest, Approximate Interval Between Onset and Death					
	/Medical Examiner	_	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):							
hap.	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
68760,	# × 6	cai	d							
P.O. Box 6	The law requires that the death certificate b ate has been signed by the attending physic page 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year					
	quires that an signed t uld be det		Part II. Other significant conditions contributing to death but not resulting in the Type II DM, Hypollyno du	A.C.C.	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown					
Il Records,		Completed by	B12 Defeciency		Was an autopsy performed? /es 2√No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
Vital	ysicien: is certific director.	Be	25. Was case referred to medical examiner?  1   Yes   2   No	26. Place of Death (Check of Death )	nniy one)  Residence 6 Other (Specify)					
of	> .∞ o	n; To	27. Manner of Death 28a. Date of Injury 28b. Time	THE SELECT THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTION OF THE SELECTIO	cribe how injury occurred					
Division	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the tuneral director.	Certification;	1 12 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	tion (Street and Number or Rural Route Number, or Town, State)					
D	pital o	Cer	29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	ath accurred at the time date and place, and due to	o the course(s) and mapper as stated					
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the t	time, date and place, and due to the cause(s)					
	Mil.		295. Signature did this of Centres	D-38754	06-24-2009.					
	5		30. Name and address of person who completed cause of death (Item 23a) (Type MALIKA - IP ASERM - 70 9 - E	ASTERN BLVD.	MD-21221					
	Sta Registi		31. Date filed (Month, JUN 3'0 2009 32. Figistrar's Signature)	pares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 1 - For State Registrar Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Yea 51-26-1 Physician PM ANTHUMY June: 21 2009 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day SEPT . 7 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Year) 929 Days Months MARYLAND 1**X** M 2 □ F 216-24-4454 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XYes 2 No Director N/A BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21231 239 S. CHESTER STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1951–62 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ☐ Yes 2X No Specify Specify: 2 WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK RAILROAD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DeCRESCENT VINCENT T.EAH SERGI ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; if item 27 is any Injury or other trau once. 239 S. CHESTER STREET, BALTIMORE, MD. 21231 STEVEN SERGI/ SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/26/09 GARDENS OF FAITH BALTIMORE, MARYLAND Name and Address of Facility INC. FUNERAL HOME 901 EASTERN AVENUE, BALTO., MD. 21231 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death intaction Immediate Cause (Final Myocardial disease or condition resulting in death) Candiolasa discusa Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: NA yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No 3 Probably 4 Unknown

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, attending p certificate has been signed by the rector, page 2 should be detached s after death.

I Director: After in by the further. within 24 hours a

Director

28a-f show

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Evanties in ust be matified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

is marked other than

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

DIMETES ME	ZLITUS.	24a. Was an autopsy performed?  1 □Yes 2 ■No 2 ■No 24b. Were autopsy findings availab prior to completion of cause of death?  1 □Yes 2 ■No 2 ■No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)									
27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?  M 1 □ Yes 2 🛣 No	28d. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occurr										

29c. License number 00032984 29d. Date signed (Month, Day, Year)

JUNE 21, 2009

State Registrar 31. Date filed (Month, Day, Year)

EREMY

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEREMY WEINER 5601 Loch RAYON BLVD # 106

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28,2009 Month **Physician** SALEFSKY, SR. JUNE 5:48 a M MICHAEL ALEXANDER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS HOSPITAL BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, SEPT . 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 10,1932 MARYLAND 76 215-28-5401 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanting must be notified at 1 XYes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3500 FAIT AVENUE 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: WHITE <u>Ş</u> 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LABORER BREWERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental F ALEXANDER SALEFSKY ပ EMMA LAWRENCE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 REBECCA McCOMB/ DAUGHTER 1910 MARS RUN ROAD, BALTIMORE, MD. 21221 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY 7/2/09 BALTIMORE, MARYLAND 21. Signature of Funer 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME CONKLING STREET, BALTO., MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) A Exest (aediac **Physician** /Medical Due to (or as a consequence of): Examiner KES hiEntory Sequentially list conditions, if any, leading to limite flats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Citie to for ar executed burial-transit and Due to (or as a consequence of): nding physician ause as the burial-Box 68760. requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Year Month 5 Other (specify) 1 ☐Yes 2 No Ö 9 Unknown <u>a</u>: 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Ves No 1 ☐ Yes 1 ☐ Yes 2 ☐ No **Director**; After this certifical in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \( \Bigcap \) Nursing Home \( 5 \Bigcap \) Residence \( 6 \Bigcap \) Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death

Natural

Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a Varietifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely 1 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29/09 D 0021859. MOHAMMADTAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMAD TAQI, M. D 23 SHIPPING PLACE, BALTIMORE, MARYLAND 21222 31. Date filed (Month, Day, Year) State JUN 3 0 Registrar

			1 - For State of Maryland / De Registrar				ealth a Death	ınd M		ene	09	208	895
Ī	Physicia	an	Decedent's Name (First, Middle, Last)					IC.	2. Date of Death Month	Day	Year		of Death
	/Medic	al	Rose Marie Scott  4a. Facility Name (If not institution, give street and number)		4b. City.	Town, or	Location o	of Death	June 26	4c. Count		9:00 h	a
	Examin	er	Golden Living Center				tmins			Car	rrol	1	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) rs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day,	/ear)	9. Birtl	hplace (State untry)	e or Foreign
	Director		Usual Residence of Decedent	rs.					May 1,	1922	1	Maryla	na
	yland how		10a. State 10b. County 10c. City, Town	or Loc	cation							10d. Inside	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any njury or other traumatic avant, the Modical Examiner must be notified at Once.	Director	MD Baltimore			dlaw	'n		10	g. Citizen of	Mhat Co		es 2X No
		Dir	10. Crarron Count		10f. Zip		21207	,	10		U.S.		
	death	Funeral	10 Graven Court  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Deced				ecity Yes or No- Rican, etc.)	14. Ra	ce - Ame	ncan Indian,	
39	urs after of, or Itea	þ	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Yes, spec		Specify:	i, Pueno	rican, etc.)	Speci	ick, White	White	
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	filed withi 1 Hygiene. other than rant, IDE M	e Co	12 17. Father's Name (First, Middle, Last)		Hous	ewil		er's Name	(First, Middle, M			<u> </u>	
Maryland	uld be Aental rked c	To Be	Vincent Promutico				R	lose	Vellri				
lary	2 short and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailin	g Address	(Street	and Numbe	er or Rura	I Route Number,	City or Towr	n, State, 2	Zip Code)	
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Vital Records,	The law ate has b page 2 s	Completed							24a. Was an autopsy perform	,	prior to death?	utopsy findin completion o	igs available of cause of
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	\		John W. Middle for no 33:	37	Vic	ton	y St	rec	t, Man	ches	ta,	MD	21/62
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 3 0 2008  32. Registrar's signature	A	9								

		-	For State	-	epartment of Health and N Certificate of Death		ene g. No. 2009	20896	
H	Division		Registrar  1. Decedent's Name (First, Middle, Last			2. Dete of Death Month		3. Time of Death	
	Physicia /Medic		Edgar H.	Smith	4b. City, Town, or Location of Death	06	27 2009 4c. County of Death	220PM	
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П	Funeral		Social Security Number     6. Se	x 7. Age (In yrs. last birti	hday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) (9. Birth	pplace (State or Foreign intry)	
	Director	d	219-34-0700 Usual Residence of Decedent	12		June 6,	173/11/10	1 ylana	
	aryland show dat	٦٢	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits 1 ☑Yes 2 ☐ No	
	the Mi	recto	10e. Street and Number	Ba	10f. Zip Code	10	g. Citizen of What Cou		
	th with 23a or 1st be	ral Di	5424 Jona	uil Ave.	21215		USI	7	
	er dea items ner mu	Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
9500-c	should be filled within 72 hours after death with the Maryland ind Mental Hygiene. In the Maryland is marked other than "natural", or items 23a or 28a-f show umatic event, It of Model Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □Yes 2 🕅 No Specify:		Specify: B	ack	
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IL Ž	should be and Mental is marked o	2	EAGA TIET 19a. Inforœnt's Name/Relationship (7)	(pe. P 1) (wife) 19b.	Mailing Address (Street and Number or Rus	al Route Number,	City or Town, State, Z	ip Code)	
Ž	and 2: lealth a m 27 is her trai		Mrs. Ola Sr	nith 5	424 Jonquil	Ave. B	alto, M.	1.21215	
9	es 1	19	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	Removal from State cemeter	Disposition (Name of y, crematory or other place)	2009 1	20c. Location - City or	rown, State	
ашшо	permit. Pag Department Important; I any injury o	1	4 ☐ Donation 5 ☐ Other (Specify,  21. Signature of Funeral Service Licens	4.3/ 1/1/	22. Name Address of Facility	-	resvill	e, Ma.	
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		8 17	23a. Parth. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	not enter the mode of dying, such as cardiac		est,	Approximate Interval Between Onset and Death	
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page?	Examiner	L	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ESRD 5M Due to (or as a consequence of	hemodialysis			unknown	
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09/90	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical		d					
COX	w requires that the death certif been signed by the attending should be detached for use as		23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of del		
	ne dea the att hed for	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month	Day Year	
r.	s that the ned by a detac	by Ph	Part II. Other significant conditions co	entributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?	
	equire: sen sig ould be					1 □ Ye	s 2 No 3 Pi	obably 4 Unknown	
င်	has be	Completed				24a. Was a autops perforr	y prior to	topsy findings available completion of cause of	
vital Records,	sician: The lav certificate has rector, page 2 s	ø	25. Was case referred to medical		26. Place of Dea		2 <b>□</b> 1 □ Yes	2 □No	
> I	ding Pnysician: The Inc.  After this certificate he funeral director, page	To B	I tes 2 Egino		·		ence 6 Other (Spe	cify)	
	ding F. h. After funera	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Fime of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred		
VISION	Atten er deat rector: by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (St City or Town	reet and Number or Ri	ural Route Number,	
5	ortal or urs aft eral Dii illed in				e, death occurred at the time, date and place			e etated	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. p	edical			d/or investigation, in my opinion, death occu				
	Vithir Vithir Comp	Me	29b. Signature and title of certifier	7	29c. License number	2	9d. Date signed (Mont	h, Day, Year)	
			30. Name and address of person who	completed cause of death (Item 22a)	(Type Print)		June - +	, - 00	
	5		RON KHATA	MR, M.D. 201	(Type, Print)  EAST UNIVERSITY PARK	wmy, Bm	TIMORE, M	AP4 CAND 21218	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrans Signature	M. C. C. C. C. C. C. C. C. C. C. C. C. C.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Physician Year 09 Nancy Patton Souders 6:20  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1014 Martin Street Prince Georges Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov 3, 1 5. Social Security Number Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖸 F 224-34-6750 79 **Director** Virginia Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐Yes 2 TXNo Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 Martin Street 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married 1 ∐Yes 2XXNo If Yes, Give Year or Dates: 1 ☐Yes 2 🗷 No þ Specify: 3√Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Lake Patton Fleta Rachel Toombs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Robinson- Daughter 1021 8th Street, Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 06-29-09 4 □ Donation 5 □ Other (Specify) Burtonsville, MD MQ0053 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature Funeral Service License 7601 Sandy Spring Rd., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 3 RONCHUPNEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and of in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYROIDISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed ZURES 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed2 1 ☐ Yes 2 ☑ No PERTENSION 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or within 24 hours af To the Funeral Di

Registrar

Medical

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

BARKWAY

29d. Date signed (Month, Day, Year)

+ 308 Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<sup>Day</sup> **Physician**  $p^{M}$ June 2009 6:30 Alice Marie Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 💢 F Months 1919 Virginia 216-52-6968 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Exeminer must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 No Funeral Director Baltimore Md. Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6451 N. Charles St. #110 21212 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Completed by White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Claud Clara Beasley Mae Justis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Alice Philips/ Daughter</u> 228 Hopkins Rd. Baltimore, Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 6-29-09 Hilltop Service Co. Towson, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MAGETIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any sealing to an accuse. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) detached for o 9 Unknown 9 Unknow ٥. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, sign I be 216WC 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2. No After this certification 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) WSD (4 Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death.
E Funeral Director; After t letely filled in by the funera Division 1 Natural 2 ☐ Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST Tonson My AMON w

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland, Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Thomas Day Year Month **Physician** 7\_00.0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5. Social Security Number 245-28-4438 If Under 24 Hrs. If Under 1 Year Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 12/24) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 MM 2□ F Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location show traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☐ No Baltimore Director 28a-f 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ò death with Kaven och 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 💥 No Specify. Completed by 3 Widowed 4 Divorced Hack "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Driver 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Health and Mental em 27 is marked o and 2 should be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4806 LOCK Raven Blvd. Bathimore, Maryland Date 20c. Location - City or Town, State Thomas Evelyn to 1/20a. Method of Disposition permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bartinore, Maryland greene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Seprice Licensee 21212 Haltimore NO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or Injury that initiated events resulting in death) Last JUNA14 Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 3 Probably 4 ☐ Unknown 2 🔽 No 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐ Yes 2 ☑ No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manher of Death 28c. Injury at Work? 28d. Describe how injury occurred 1-☑ Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

15 V State

DHMH 17 Rev 1/2001

State Registrar

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 3 0 2009

32. Registrar's ignatur

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Balhare

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 18 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9209 Saudra Park Road Baltimore Perry Hall If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 □ F 213-20-0603 34Yrs Director 10/22/1924 Balt. Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinating the notified at Baltimore Maryland Perry Hall 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with United States 9209 Sandra Park Road 21128 Funeral America permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ...: any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2☐No Specify: Aq. If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther B. Koller Agnes L. Kilduff ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Franklin J. Thurston/spouse 9209 Sandra Park Road Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel - Bel Air 20c. Location - City or Town, State Date 20a Method of Disposition June 26. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Forest Hill, Maryland 21. Signature of Fyneral Service License 22. Name and Address of Facility eacceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road baryland 21093 Timonium, Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) erebrovasc /Medical Due to (or as a consequence of): Examiner THEVO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) 1 ☐Yes 2 2 10 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 含 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown s peen s Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performed Division of Vital 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 1 atural 5 Pending investigation spital or Attendii nours after death. neral Director: A death. Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Hospital 29a. Certifie 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of ompleted cause of death (Item 23a) (Type, Print) 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, Physician 2009 **EARLENA** TAYLOR JUNE. 5:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year, 1 □ M 2 🖾 F Months Davs Hours 227-22-3607 85 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10h County 10c. City. Town or Location in than "natural", or items 23a or 28a-f show the Medical Examinan rough be notified at 1 ☐ Yes 2X No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Forest Valley Drive 21050 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Evanina. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: Completed by 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 Medicine Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Hibbert Hamilton Lillie Florence Mullins ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Day / Grandson 201 High Street, Stewartstown, PA 17363 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 6-29-09 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name end Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 21. Signature of Funeral Service Licensee 23a. Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONG est **Physician** errs /Medical Due to (or as a convequence of): Examiner dic 2shes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.O. | s been signed by the should be detached 1 Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 s page 2 autopsy performe of Vital 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check onlone) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 28136 30. Name and address of person who ause of death (Item 23a) (Type, Print) ROBERT DUNCAN 615 WEST MACPHAIL ROAD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

BEL AIR, MD.

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modferl Exeminer must be notified at once. Baltimore, Maryland 21215-0036

Directo

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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miner	48			COD									2. Date of Do Month June	eath D	av Ye		3. Time	of Death
rai		a. Facility Name ( Washi	If not institut	ion, glv	street and no				4b. City, 7	Town, or			June	40	C. County of D	eath		, ,
tor	5.	Social Security I	Number	6. S		7. Age (In yr	s. last bi	<i>rthd</i> ay) Yrs.	If Under		If Under Hours	Min.	8. Date of Bi (Month, D Jan 16	irth <i>ay, Ye</i> a <i>i</i>	9.	Birthp Coun	lace (State	or Fore
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I Director	$\perp$	De. Street and Nu	ımber				Hagerstown  10f. Zip Code 21740							10g. Citizen of What Country?				
once.  To Be Completed by Funeral Director	1	1. Marital Status 1 ☐ Never Man 3 █ Widowed	_		Armed F	2 □ No live	u.s. unk	1	Vas Deced f Yes, spec	ify Cuba	ispanic O In, Mexica Specify	ın, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V Specify:	Vhite,		
Completed	-	Elementary/Second 12	ondary (0-12)	nest gra	de completed	(1-4or 5+) 5+	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  professor col1							colle		dustry		
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	2	0a. Method of Dis 1 □ Burial 2 4 □ Donation	Cremation			n State	Place of cernete	of Dispo ery, cren	sition (Nam natory or ot	ne of ther plac	e)	D	ate	20c.	Location - City	or To	wn, State	
Medical Examiner	o c c c c c c c c c c c c c c c c c c c	mmediate Causilsease or condition (seculting in death) sequentially list cause. Enter Undarase (Disease or at initiated event esculting in death)	art failure. Li TFinal on onditions, onditions erlying r injury s	st only	a. Due to	each line.  o (or as a conse	equence	of):	He		_						Interval B Onset and	
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ted by PI	P	art II. Other sign	ificant condi	tions c	ontributing to	death but not re	esulting	in the ur	nderlying ca	ause give	en in Part	I.			use contribu		he cause o	
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To Be	L	5. Was case refe examiner? 1 2 Yes 2	]No	, al		Inpatient 2				Oth	or:	lursing Ho		sidence	6 □Other (	Speci	fy)	
Certification:		7. Manner of Dea 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 ☐ Pend inves 6 ☐ Coul dete	stigation d not be mined	28e. Place build	e of Injury nth, Day, Year)  L. L. L. L. L. L. L. L. L. L. L. L. L. L	home, facify)	Vus	eet, factory,	office	Yes 25	2M6 :	730	(Street a swn, Sta	hurs and Number of the	4	1/2/20	umber,
Medical Certification: To Be Completed by Physic		9a. Certifier (Check only one)  9b. Signature and			ysician: To the niner: On the and ma	ne best of my k basis of exami nner stated.		-	29c	. Licens	e number			29d. E	Date signed (M	Nonth,	Day, Year)	
2	29a. Certifier (Check only only only only only only only only													34	ue i	> 1	20	9
2		0. Name and add		n who	completed cau	use of death (It	em 23a)	(Type,	Print)	,	/ ,		. 6/	11	of inst	W	7 18	<del>-</del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 08:30 AM BARNEY, TAYLOR 2009 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Genesis RAndallstown Randallstown 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) 1959 North Carolina If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F June 18, 219-04-5119 50 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2X No Funeral Director Randallstown MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be **USA** 21133 9109 Liberty Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1X Never Married 2 ☐ Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Hygiene. automotive 1aborer other 18. Mother's Name (First, Middle, Maiden Surname, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) unk Be Annie Morehead 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 910 W. Saratoga St. #2B Baltimore, Maryland 21223 Pamela Taylor/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 NOTTHER (Specify) in state 21. Signature of Funeral Service, Licensee, Ron Wade State Anatomy Board 655 W. Baltimore Street Baltimore, Maryland 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate C e (Final disease or con resulting in death) weeks Toxoblasmosis **Physician** /Medical Due to (or s a consequence of) Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the l 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death signed by the a 1□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was autopsy performed? certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) injury 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058965 Khonvaj 2009 Samon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9109 Liberty Koad Randallstown KHAWAJA, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

		,	For State	State of M	laryland / Depa	artment of I		Mental Hy	C12	0.0	20001
			Registrar  1. Decedent's Name (First, Middle, La	st)	001	Timodic or	Dealit	2. Date of De	Reg. No.	1117	3. Time of Death
	Physici		, , , , , , , , , , , , , , , , , , , ,	. Terzi	1			June 2	25, 200	Year O	4:20pm
- wing	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat		4c. County		
أمي	_Adiiiii		Future Care (	anton Ha	arbor	Ва	ltimore				
	Funeral Director		5. Social Security Number 6. S 213-66-9511	Gex 7. A	ge (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, D) Sept	18,1954	9. Birth Cou	place (State or Foreign ntry) MD
	pe ,		Usual Residence of Decedent								10.1 1-11-01-11-11-
	arylar show	5	10a. State 10b. County		10c. City, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M	ecto	10e. Street and Number		Darc.	10f. Zip Code			10g. Citizen of N	Mbat Cou	
	with with la or	Funeral Director	1300 S. Elwo	od Aveni	10	Toil. Zip Code	21224		USA		
	ns 23	era	11. Marital Status	12. Was Decedent Armed Forces		Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No	o- 14. Rad	ce - Ameri	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Exactions and Its incitific once.	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	an, Mexican, Puer Specify:	to Rican, etc.)	Specify Specify	ck, White, y: <b>W</b>	<sub>etc.</sub> nite			
9-0	2 hou	ted	15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occu	pation		16b. Kind of B	usiness/Ir	idustry
21215-0036	hin 73 e. an "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or	54) life.	DO NOT use retire	during most of wo	rking			
21	filed within Hygiene. wher than "	S	10th		Disa	abled	T				
nd	12 should be filed within 'h and Mental Hygiene. h and marked other than "' raumatic event, tre Me	Be	17. Father's Name (First, Middle, Last						e, Maiden Suman	ne)	
yla	d Mer d Mer narke	은	Benjamin Be					an Kite			
Maryland	d 2 sh th and t7 is r traur		19a. Informant's Name/Relationship ( Dianne Morris				tand Number or R. Shore Di		-		
ā,	Health tem 27 i		20a. Method of Disposition	, 515001	20h Place of Dispo	sition (Name of			20c. Location		
Baltimore,	permit. Pages Department of Important: If ite any Injury or o		1 ☐ Burial 2 ☐ XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Dayview		OLA	2 <sup>Date</sup> /09	Baltim		MD
Ball	permit Depar Impor any In once.		21. Signature of Funeral Service Licer	Per	-7 22	2. Name and Addre	ess of Facility 3	00 Mace eral Ho	e Ave. ome of	Balt Ess	to. MD ex 21221
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory a	arrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	( Insuie	Herati Jo	miluse					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):						
١.	LAGIIIIICI	J.	Sequentially list conditions,	b							-
1/2	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of):						
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9	rtifica ng phy as th	ledi									
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	☐ Ectopic pregnan ☐ Other (specify) _	су			ate of deliv	very Day Year
σ.	that ned by deta		Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?
rds	w requires to be a signal should be a	d by	Waltes - icis	our des	enteut.			1 🗆	Yes 2 □ No	3□ Pro	bably 4 Hunknown
of Vital Records,	e law rei has bee ie 2 shou	Completed	Hyporum 6					24a. Was	psy	prior to co	opsy findings available ompletion of cause of
<u>a</u>								1 □ Yes	ormed? 2 🖽 No	death? 1 ☐ Yes	2 🗆 No
Ζ̈Ϊ	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo	Hospital:		Oti	hor:	ath (Check only			
of	Phys	<u>1</u>	27. Manner of Death	28a. Date of Inj	tient 2 ER/Outpatier jury 28b. Time o	IL 3 DOA	4 Lunivursing i		how injury occur		ify)
Division	Attending or death. ector: After by the fune	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay, Year) Injury		rḱ? ]Yes 2□No		, ,		
<u>Visi</u>	Atter	ifica	3 Suicide 6 Could not b	1 28e. Place of in	njury - At home, farm, str etc. (Specify)	eet, factory, office				ber or Rui	ral Route Number,
Ö	tal or s afte al Dir	Certification:	4   Hornicide	building, e	ite. (Specify)			City of 10	wn, State)		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exam	nysician: To the bes niner: On the basis and manners	t of my knowledge, deat of examination and/or in stated.	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and m , date and place,	anner as and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	ed (Month	, Day, Year)
			ference (a	(Junes)		DI	9667		06-20	o 7c	09
	3		30. Name and address of person who	completed cause of	-	Print)	4 508	Cale 2	mi. D	ماه	009 wh 21061
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12135 AM enes JUN E 26 2009 liam /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospital Baltimore Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 MM 2□ F Director 217227914 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinating to ust by notified at 1 Yes 2 No Director mD timore 10e. Street and Number 10g. Citizen of What Country? USA Completed by Funeral Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Borden is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. Balb.MD 21229 rnestine 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Months Heast Sequentially list conditions, it am, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy requires that the death in the past 12 months? Day 5 Other (specify) P.O. 1 □Yes 2 □No the 9 Unknown Š cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy perform diceaso Vital 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation within 24 hours after usegon.

To the Funeral Director: After the funeral Director of the fure fure fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for the fure for 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar SonNath

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

900 Caton

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Las 2. Date of Death **Physician** 9:30 0 Line an 2009 /Medical tution, give street and number) 4c. County of Death Fown, or Location of Death Examiner Home Pattimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day Security Number . Age (In yrs, last hirthday)
Yrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🗷 F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at more 1 KYes 2 No Director 10f. Zip Code ò items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White-atc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nnt of Health and Mental Hygiene. nnt: If Item 27 Is marked other than "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 5 3 ☐ Widowed 4 🗹 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) lementary/Secondary (0-12) College (1-4or 5+) UNKNOWN one make 17. Father's Name (First, Middle, Last) Be MAROCU ပ္ City or Town, State, Zip Code) Important: If item 27 is any injury or other tra SAHIMORE 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3 Removal from State 21. Signature of Funeral Service Ligensee acility Joseph 40 N. Fuffen Ave 2 . Part1. Enter the disease, or complications that caused the death. shock, or leart failure. List only one cause on each line. In mediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence) Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, neumonia **Physician** 2 nucks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 attending physician Be Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) P.0. been signed by the s should be detached t 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 👿 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s was an autopsy performed?
Yes 2 No Hypertension certificate 2 Coronar 1 □Yes 2 🗆 No 1 Tyes 25. case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No hours after death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12754 June 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimory MD-21227 Ferry Rd ,4067 Hollins GEETHA KAJA MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2009

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 8:28 AM tarrison 2009 23 UNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA SINAI HOSPITHL OF BATIMORE BALTIMORE CIP 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min. 219-62-4426 53 Director Maryland 1955 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Tyes 2 No Funeral Director salt more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: Specify: Black Completed by 3 ☐ Widowed 4 Novorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 leacher injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 19a. Informant's Name/Relationship\_(Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevenswood Health a 8521 Bunn-Cousin Windsor Mill, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metvo Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 to 1 ☐ Burial 2 ☐ remation 29/09 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howeld 21. Signature of Funeral Service Licenses 4600 Liberty Ave, Batto MD 21267 Heights 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as chidiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COMPLICATIONS OF ADVANCED HIV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HYPERTENSION has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RELTAL CARCINOMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 1 No page certificate 1□ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No after death Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0750693 - 110 JUNE 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALDEN G. PEOPLES, MB SNAI HOSPIPAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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3

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day 2009 28, 3:37 P M Lillian M. Wallett June 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 | March 18,1925 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M **X** X F 84 Maryland 212-22-8380 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes XXNo Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 U.S.A. 238 Homevale Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes XX No White Specify: ¥₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Grocery Store Cashier Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Sciarretta, Sr. Concetta Perrotta 19a. Informant's Name/Relationship (Type. Print) .Brother-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry L. Wallett 1871 Deer Park Rd. Finksburg, MD 21048 20b. Place of Disposition (Name of Competers crematory arother place). Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State XIX Burial 2 Cremation 3 Removal from State Veterans Cemetery July 6, 2009 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Pervice Licentia 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Wellas 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SC 10 mi disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

a or 28a-f show be notified at 28a-f show

items 23a cliner must be

r than "natural", or iten

Director

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Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23.

ulth and Mental Hygiene. 27 is marked other than ' r traumatic event, the Me

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar signed by the a after death.

Director: After this certificate has I in by the funeral director, page 2 s

Physiclan: The law requires that the death certificate be executed

I or Attending I

To the Hospital of within 24 hours a To the Funeral D

filled in by

P.O. Box 68760,

Division of Vital Records,

Physician/Medical þ Completed Be Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2, 🗷 No 9 Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 □ Yes

2115

25. Was case referred to medical examiner? 1 Yes No 27. Manner eath 2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only

5 Pending investigation 6 ☐ Could not be

Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DCA Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature an

29c. License number

29d. Date signed (Month, Day, Year)

Medical

Raman 31. Date filed (Month, Day, Year, JUN 3 0 2009

ahena 32. Registra 's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Demetrica D. Wright 3,30PM 2 6 --7 -09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Manor Care of Dulaney 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number Age (In yrs. last birthday, **Funeral** 1 □ M 2 🗓 F Director 49 215-76-8180 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No notified Director Baltimore MD NΑ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or r USA 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must t 21216 2202 West North Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. African 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 ☐ No Specify: Specify: American þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygienc Important: If Item 27 is marked other tha inpury or other traumatic event, the isone. Company Offices Counselor <u>11th Grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown Frances Galloway ပ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 5 19a. Informant's Name/Relationship (Type. Print) 2719 W. Belverdere Avenue Baltimore, MD. William Galloway-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-07-09 Lansdowne, MD Zion Cem. 21. Signature of Funeral Service Licens 22. Name and Address of Facility WYLIE FUNERAL HOME P.A.MD 21217 Gilmor Street Baltimore, 0 638 Ν. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician InTracrania-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Steam the burial-trai Due to (or as a consequence of attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si , page 2 should I Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No certificate 1∐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA <sup>2</sup> 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

requires that the death certificate be executed Box 68760, P.O. Division or Vital Records, the Hospital or Attending Physician:

death.

within 24 hours after c

To the Funeral Direc

completely filled in by

Medical

72 hours after death with

Baltimore, Maryland 21215-0036

After this certification funeral director, p Director: /

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only

1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) H0054424

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hammonds lane #LZ Brocklyn, MD 21225 Sadi rus 60

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 281 per me, g392,06/30/09dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Vear **Physician** Weisberg Joseph 6 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Randallstown Season's Hospice at Northwest Mospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 8. Date of Birth (Month, Day, Year) 10/08/1920 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 217-12-9737 88 Director MD Usual Residence of Decedent build be filled within 72 hours after death with the Maryland Mental Hygiene.

Area other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examinational be notified at 1 Tyes 2X No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3110 LIGHTFOOT DRIVE 21208 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **OWNER** LIQUOR STORE of Health and Mental Hyginitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EDWARD** WEISBERG REBECCA HIMMELFARB ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS WEISBERG / WIFE 3110 LIGHTFOOT DRIVE, BALTIMORE, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If ite any injury or o ō 1 ABurial 2 Cremation 3 Removal from State BALTIMORE HEBREW 06/29/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. Total 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death whitelows Immediate Cause (Final disease or condition resulting in death) End **Physician** stage Alzheimers years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: signed by the attending physician and burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnanc Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> ongestion 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performe certificate 1 □Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Inpatrent Hospice Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1XYes 2 □ No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Medical Certification: 1 □ Natural 5 ☐ Pending investigation June 15,2009 UNKnown 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number of Rural Route Number, City or Town, State) 3110 Lightioot Drive, Pikesville, MD determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital Hospital or Attending Physician: after death.

Director: After this within 24 hours a

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Roggen

31. Date filed (Month, Day, Year)

JUN 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5400

Old Court Road

32. Registrar's Signature

29c. License number

D 35844

Suite 108 Randallstown MD

29d. Date signed (Month, Day, Year)

2009

21133

		1 - State of State of Registrar		artment of Health and Natificate of Death		ene J. No. 2000	2001
Physici		1. Decedent's Name (First, Middle, Last)  Andrea Womack			2. Date of Death June	Day Zear Zooq	3. Time of Death 8:55 PM
/Medio		4a. Facility Name (If not institution, give street and numb Union Memorial Hospi	· ·	4b. City, Town, or Location of Death Baltimore	Vario	4c. County of Death	0.05
Funeral Director			Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, )	year) 9. Birthp Cour 1968 North	place (State or Foreign htry) n Carolina
ryland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation			0d. Inside City Limits
h the Ma or 28a-f s or cullies	irecto	MD  10e. Street and Number	Baltimo	10f. Zip Code	100	g. Citizen of What Cour	1√Yes 2 No ntry?
r death wit ems 23a c	Funeral Director	312 Eastway  11. Marital Status	1:5?	21212 Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Americ Black, White,	
nours afte ural", or It		1 XNever Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	XINo es:	I∐Yes 2∏ No <i>Specify:</i>		Specify: bla	ck
within 72 h ene. <b>than "na</b> t	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4-11)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		6b. Kind of Business/In	dustry unk
should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or Items 23a or 28a-f show umatic event, I're Madical Evamina must be notified at	To Be Co	17. Father's Name (First, Middle, Last)  Jerome Morgan	I		ne (First, Middle, Ma et McDuffi		0
d 2 shoulth and M	-	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or Ru	ral Route Number, (	City or Town, State, Zip	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, The Madical Examination must be notified at once.		Judith Johnson/aunt  20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify) in state	20b. Place of Dispos cemetery, cren	Melville Avenue B sition (Name of natory or other place)		MD 21218	
permit. f Departm Importar any inju		21. Si nature of Emparishment S. Wade, Di	rector S	Name and Address of Facility Late Anatomy Boar		Baltimore	Street
Physician /Medical	8 1		sed the death. Do not enter h line. TC Shock	Baltimore, MD 212 er the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
ificate be executed was a physician and was the burial-transit	I Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):  SA Batture as a consequence of):  Ctive end as a consequence of):	•			
ath certi ittending or use a	Physician/Medical		h 2 Fetal death 3 to at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv	ery Day Year
quires that the de in signed by the a uld be detached f	by	Part II. Other significant conditions contributing to deat	h but not resulting in the ur	nderlying cause given in Part I.		acco use contribute to t	/
n: The law requir ficate has been s r, page 2 should l	Completed					prior to co death? No 1 Yes	opsy findings available mpletion of cause of 2 No
To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page is	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident  1 Investigation	<del></del>	t 3 DOA Other: 4 Nursing H	th (Check only one) ome 5  Residen 28d. Describe how	ce 6 □Other (Speci	fy)
To the Hospital or Attend within 24 hours after death To the Funeral Director; , completely filled in by the f	Certifica	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, streetc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
n 24 hour e Funer.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the buse and manner.	s of examination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cau rred at the time, dat	use(s) and manner as a te and place, and due t	stated. o the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	Y.D.	29c. License number AT 2438946		d. Date signed (Month, June 16,	
		30. Name and address of person who completed cause CELESTE C.L. QUI an ZOV	1, M.D. UI	nion Memovial t	tospital.	MD	
Sta Registr		31. Date filed (Month, Day, Year) 22. Reg	istrar's Signature	Rid			

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	arylan		artment of F rtificate of I			_	giene Reg. No. 2	000	1 0001
			Decedent's Name (First, Middle, Last	)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-		2. Date of De	ath	V	3. Time of Death
	Physici: /Medic		PHYLLIS J. V	<b>VOMACK</b>						Month JUN	Day E E D ,	Year 2(21(21)	8:45F M
A A A	Examin		4a. Facility Name (If not institution, give Saint Joseph		Cent	ter	4b. City, Town, or		n of Death Tows o	n	4c. Count		imore
	Funeral		5. Social Security Number 6. Se	TM 2/XE		as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Und Hours		8. Date of Bir (Month, Da	ıy, Year)	Cou	place (State or Foreign intry)
	Director		230–40–2137 Usual Residence of Decedent	/	2					AUGUST	13,1936		VA
ryland	wo to		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
ie Mai	8a-fs	Director	MD		В.	ALTIM(							1 □XYes 2 □ No
with th	Pa or 2		10e. Street and Number	am a mm	000		10f. Zip Code				10g. Citizen of		intry?
eath	ns 23	Funeral	1100 BOLTON STREE	T APT.  12. Was Decedent E		3. 13.	Was Decedent of H		Origin? (Sp	ecify Yes or No	US 14. Ba		ican Indian,
d 21215-0036 filed within 72 hours after death with the Maryland	th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it., Medical Exarcity or coust to multipled at	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give			If Yes, specify Cuba 1 □ Yes 2 ☑ No	an, Mexic Speci	can, Puerto	Rican, etc.)	Bla	ck, White,	
<b>21215-0036</b> d within 72 hours aff	ural",	d by	3 Widowed 4 Divorced	Year or Dates:			**		iy.		Speci	BLA	
<b>15-</b> 1	"nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during m	ost of work	ing	16b. Kind of E	Business/Ir	ndustry
212   withi	r than	mo.	Elementary/Secondary (0-12)	College (1-4or 5	+)		DIETICIAN	_			HOUS	E OF	HOPE
be filed	at Hygiene. I other than " event, it	Bec	17. Father's Name (First, Middle, Last)		•				ther's Name	e (First, Middle	, Maiden Surna		
arylaı should b	Ment arked atic e	2	JOHNNIE B. ANDERS							IE WHIT			
- N	h and 7 Is material		19a. Informant's Name/Relationship (T) HENRY WOMACK/HUSE				ng Address (Street <b>BOLTON</b>				er, City or Towr <b>LTIMORE</b>		ip Code) <b>21201</b>
1 and	Heali tem 2 other		20a. Method of Disposition		20b. P	lace of Dispe	osition (Name of			Date	20c. Location		
altimore, rmit. Pages 1 ar	Department of Health Important: If Item 27 any injury or other trong.		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Ce	emetery, cre	matory`or other place NAL MEM.		Y.IIII.	1.2009	T.AIIR	EL, M	m
Balti permit.	porta porta y inju		21. Signature of Funeral Service Licens		4								IS F.H., INC.
<b>n</b> 8	. 플 등 등		James G.	mort	on		701-31 LA				IMORE,	MD 2	21217
			23a. Pow . Enter the disease, or composite ck, or heart failure. List only o	lication /that caused ne cau e on each lin	the death	. Do not en	ter the mode of dyir	ng, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	nysician		Immediate Cause (Final disease or condition resulting in death)	u			PTIC SH	OCK					
	Medicat kaminer		resulting in deduct)	Due to (or as		ence of):						1	
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		ence of).							
cuted	nd ransit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
<b>8760,</b> 9 cate be exe	sician and burial-tran		resulting in death) Last	Due to (or as	a consequ	ience of):							
18760,91. icate be executed	physic the b	dical		d,									
	attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncy					334 D	ate of deli	Werv
. Box 6 death certif	e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at			☐ Ectopic pregnanc ☐ Other (specify) _	У				tonth	Day Year
at the	by the a	hys	9 Unknown	9 Unknown									
~	gned oe de	ठ्व	Part II. Other significant conditions co	-	ut not resu	Ilting in the u	nderlying cause giv	en in Pa	rt I.		V		the cause of death?
<b>ord</b> requir	s peen si should I	eted	MULTIPLE SCLE							1 🗆	Yes 3 No	3   Pro	obably 4 Unknown
Records, he law requires th	01 CI	Completed	OLD CEREBROVAS	CULAR A	CCID	ENT				24a. Was			topsy findings available ompletion of cause of
_	certificate ha		25. Was case referred to medical							1 □ Yes	2 No	1 🗆 Yes	2 No
Vital /sician:	s cert directo	To Be	examiner?	Hospital:	ent 2 🗆	FB/Outnatie	nt 3 DOA Oth	er:		h (Check only o	o <i>ne)</i> idence 6 □ O	ther (Spec	nifu)
נס ר נח P	h. After this funeral dir	n: T	27. Manner of Death	28a. Date of Inju	ry	28b. Time o		y at			how injury occu	<del></del>	ay,
SIO	leath. tor: Af the fur	atic	1 Natural 5 Pending investigation	(month) Day	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2	□No				
DIVISION OF lor Attending Phy	within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At ho c. <i>(Specif</i> y	me, farm, st /)	reet, factory, office				Street and Num wn, State)	ber or Ru	ral Route Number,
L spital	ours after o eral Direc filled in by		29a. Certifier Certifying Phy	rsician: To the best of	of my know	wledge, dea	th occurred at the til	me, date	and place	and due to the	cause(s) and r	nanner as	stated.
e Hos	within 24 ho <b>To the Fune</b> completely f	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	f examinat	tion and/or i	nvestigation, in my o	pinion, o	death occur	red at the time	date and place	, and due	to the cause(s)
Toth	withir To th comp	Me	29b. Signature and title of certifier	110.	. 1A	1 k	29c. Licens	e numbe	er		29d. Date sign		
		115	► A·C	1. Helo	u, v	1.1.	DØØ	176	95		June	25,	2009
	4		30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type,	Print)						
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	711 () 9 ture	LER DRI	UE	TOWS	ON. MA	RYLANI	213	204
	Registr	-	JUN 3 0 2009	Senta		par	Kal						

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Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast) Vincen			Dealli	-	2. Date of Deat	g. No. h		3. Time of I	**** *** **
edical Exami			Vincent We		waru			Month June 24, 2		Year	1836 h	
		4a. Facility Name (if not institution,				b. City, Town, or	Location of D			County of Deat	h	
		Howard County General	l Hospital			Columbia			Но	ward		
Funeral		Social Security Number 6.	Sex 7.	Age (In yrs. Ia	est birthday)	If Under 1 Yea			h(MM/DI		rthplace (Statountry)	e or Foreign
Director		213-47-7745	X M 2 F	13	Yrs	Months Day	/s Hours	Min. 01/0	3/19		Virqi	nia
		Usual Residence of Decedent				<del></del>			-, -,			
* any		10a. State 10b. County		10c. City,	Town or Locati	on						City Limits
land f shov	5	MD Howard	E	Sy	kesvil.							2 XNo
Mary 28a-	Director	10e. Street and Number				10f. Zip Code		10		n of What Co	-	
n with the Maryland ms 23a or 28a-f show any be notified at once.		12260 Howard Loc				2178				ted Sta		
th wit	uneral	11. Mantal Status  1 XNever Married 2 Marr	12. Was Decede			s Decedent of Hi es, specify Cuba		(Specify Yes or No- uerto Rican, etc.)	- 1	<ol><li>Race - Ame White, etc.</li></ol>	erican Indian,	Black,
er dea	교		1 Yes	2 X No		Yes 2 X No	o-o-if-u			nooifie 7	·	
rs afte	by	Widowed 4 Divorce     Divorce  15. Decedent's Education (Specification)	or Dates:	completed)		t's Usual Occupa		d of work done		pecify: As:		
2 hou "nat	ted	Elementary/Secondary (0-12)	College (1-4			ost of working life			100.14	io oi booiiioo		
336 thin 7 than than	nple	7		,	Sti	udent				Educat:	ion	
5-06 ed wi lygier other	Completed	17. Father's Name (First, Middle, Li	ast)				18.Mother's N	Name (First, Middle, I				
21, be fill ntal F rked	Be	Robert M. Woodwa	ard				Kyong	H. Kim				
221 hould and Me is ma	ဥ	19a. Informant's Name/Relationship			4	•		r or Rural Route Nun				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Robert M. Woodwa	ard/Father					Drive Syl		ille, I		
Baltimore, permit. Pages I ar Department of Hee Important: If iten		20a. Method of Disposition  1 XBurial 2 Cremation	3 Removal from	State Mt	remator prot	sition (Name of ce	emetery,	7/7 <mark>/09</mark>	20c. Lo	cation - City t	or rown, State	3
Page nent (		4 Donation 5 Other Spec		- Cr	est Lav	vn Mem.	Gard.	7-6-2009		rriotts		
Salt ermit. eparti n port		21. Signature of Funeral Service Li	censee	M010	44 22. N	Name and Addres	s of Facility	Harry H. V	Witz	ke's Fa	amily 1	FH Inc.
	6 47	23a. Part I. Enter the disease, or co	week		4	112 Old	Columb	ia Pike E	llic	ott Cit	ty, MD	21043 mate Interval
Physician /Medical		failure. List only one cause or	n each line.		, Do not enter t	ne mode or dying	, such as card	ilac or respiratory arr	est, 51100	k, or fleat	Between	n Onset and Death
vaminer		Immediate Cause (Final disease or condition resulting in death)	a. Head Injuries  Due to (or as a co		٤١.						10	Jean .
			b.	insequence o	1).							
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence o	f):							
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n of Vital Records, P.O. Box 68760, the Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED	X AMENDED	#1 pe	r ME ga	392 6/30 893 7/15	/09 TT					
'60, ate be	Med	IF FEMALE:	23c. If yes, out			075 1/15	7,05 11		23d.	Date of deliv	ery	
687 ertific ding p	ian/	23b. Was decedent pregnant in the past 12 months?	I I Live birti		_	etal death 3	Ectopic p	regnancy		Month	Day	Year
Box 68760 e death certificate b the attending physical ed for use as the bu	/sic	1 Yes 2 No 9 Unkn		t at time of de	5 O	ther (Specify)			1			
D. E trithe d by the		Part II. Other significant conditio			esulting in the	underlying cause	given in Part	I. 23e. Did t	obacco u	se contribute	to the cause	of death?
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Division of Vital Records, related retaining Physician: The law required and retained the benefit and birector: After this certificate has been sited in by the functal director, page 2 should be	Completed							24a. Was			autopsy findi	
e has	ם							auto perfo	ormed?	death	?	-
n: Th tifical or, pa		25. Was case referred to medical				26.Plac	ce of Death (C	heck only one)	2 INC	1 🗸		2 No
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endir sath.	Ë	1 Natural 5 Pendir		09	1705 hrs	1	Yes 2 V N	Passenger	auto a	uto collisio	on .	
Visi or Att fter de jirect in by	iji	2 Accident Investi 3 Suicide 6 Could	28e Place o	f Injury - At h	ome, farm, stre	et, factory, office	building, etc.	28f. Location ( or Town,		nd Number or	Rural Route	Number, City
Filled La	Certification:	4 Homicide determ	Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Company of the Compan	_ocal Stre	et			Route 32 at I	River Ro	ad, Sykesvi	lle, MD	
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director; /		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowled	ge, death occu	rred at the time,	date and place	e, and due to the cau	ise(s) and	d manner as s	tated.	
To the Complete	Medical	one) 2 Medical Exam	iner:On the basis of e and manner stat	examination a ed.	and/or investiga			irred at the time, date				
	Σ	29b. Signature and title of certifier		_/	4		nse number			Date signed (		ear)
		(all	11/6			0.0	S.M.E.		June	e 25, 2009		
_		36: Name and address of person w Zabiullah Ali, M.D. A	tho completed cause ssistant Medical	,		nn Street, Ba	Itimore MI	D 21201				
				examiner strar's Signati			idinore, ivil				_	
Regis	tate trar	11101 4 11	2009 Den	w	D. 190	ale						

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UNK	UNK		State of Maryland / Department of		/giene	21	009 209
			I- For State Certificate of Registrar	Death	Reg.	No.	
Max	Physicia		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month D	ay Year	3. Time of Death 2107 hrs
we	dical Exami	ner	EMILY THOMAS WILEY	b. City, Town, or Location of Death	June 21, 20	4c. County of Dea	
4			4a. Facility Name (if not institution, give street and number)  38 Torque Way	Middle River		Baltimore Co	
	E		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth	MM/DD/YYYY) 9. E	Birthplace (State or Foreign
	Funeral Director		_ v×   10	Months Days Hours Min.	Sept 21		Country) Maryland
			213-52-6623 1 M MAF 48 Yrs.  Usual Residence of Decedent		130pt 21	, 1500	nai y i una
	any		10a. State 10b. County 10c. City, Town or Locati	on			10d. Inside City Limits
	nd how ce.	_	Maryland Baltimore   Middle Ri	ver			1 Yes 2 No
	arylar 8a-f s at on	읈	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
1486	he M t or 2 ified	Director	38 Torque Way	21220		USA	
y	with and 23s	rai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? ( Sp		14. Race - Am	erican Indian, Black,
1	death r iten	Funeral	1 Never Married 2 X Married Armed Forces?	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc	
	after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes XX No specify:			hite
	nours	be	during m	t's Usual Occupation (Give kind of vost of working life. DO NOT use reti		6b. Kind of Busines	ss/Industry
	16 n 72 h nan ", ical E	olet	Elementary/Secondary (0-12) College (1-4 or 5+)	- vale		Doto	: 1
	withi withi giene.	Completed	12 Cle		(First, Middle, Ma	Reta	11
	al Hynel	Be C	Andrew Banks Thomas			ll Ridgel	v
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show- injury or other traumatic event, the Medical Examiner must be notified at once.	.O.	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing	Address (Street and Number or	Rural Route Numb	er, City or Town, St	ate, Zip Code)
	AD 2 sho 1 and 27 is mati		Andrew Banks Thomas Father   1616	Pot Spring Road	Lutherv	ille, Mar	yland 21093
	e, P		20a. Method of Disposition 20b. Place of Dispos	sition (Name of cemetery,	Date	20c. Location - City	or Town, State
	ages at of at: If		CoopMound	t Crematory June	26 200°	9 Raltim	ore. Maryland
	Baltimore, Demit Pages I an Department of Hea Important: If iten		4 / Donation 5 Other Specify: UT CEITHOUTH 21 Fignature of Funer Service License 22. N	Name and Address of Family to he	ell-Wiede	efeld Fun	eral Home Inc
	B Per Julia		Downin a Vesten (Proposition)	6500 York Road I	Baltimore	e, Maryla	
	Physician		23a. Part I. Enter the displace, or complications that caused the death. Do not enter the failure. List only one cause on each line.	he mode of dying, such as cardiac o	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
, -	/Medical Examiner		Immediate Cause (Final disease a. Myocardial fibrosis				Death
	.xammer		or condition resulting in death) Due to (or as a consequence of):				
		<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		nin	cause. Enter Underlying Cause (Disease or injury that initiated				
	sd sat	Examiner	events resulting in death) Last Due to (or as a consequence of):				
	ecute and		d	, g893 7/22/09 T	r –		
	tox 68760, eath certificate be execute attending physician and for use as the bunal - tran	Physician/Medical	ACTUAL DES	, 8020 1, ==, ==		Local Data Carlo	
	68760 sertificate to ding physise as the bu	W/W	IF FEMALE: 23b. Was decedent pregnant in the 2 23c. If yes, outcome of pregnancy	etal death 3 Ectopic pregn	ancy	23d. Date of deli Month	Day Year
	x 68 h cert tendir use a	cia	past 12 months?  4 Pregnant at time of death 5 Of	ther (Specify)			
	Box e death c the atten ed for us	hys	1 Yes 2 No 9 Unknown 9 Unknown				
	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transition.	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			e to the cause of death?  Probably 4 V Unknown
	S, P irres ti signe d be d						
	of Vital Records,  ng Physician: The law require  the this certificate has been si  meral director, page 2 should b	Completed			24a. Was a autops	y prior	e autopsy findings available to completion of cause of
	ecc he lay ate ha	mo			perform 1 <b>V</b> Yes 2		Yes 2 No
	an: T entific tor, p		25. Was case referred to medical	26.Place of Death (Check	only one)		
	Vital   hysician: this certif	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other Nursi	ng Home 5 F	Residence 6 🗸 C	other: Scene
	1 of Ving Phy		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of		28d. Describe h	ow injury occurred	
	Division tal or Attendin rs after death.  al Director:  Aled in by the fu	aţi	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
	Division pital or Attend ours after death teral Director: filled in by the	ific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (S or Town, St		r Rural Route Number, City
	Dipital ours a filled	Certification:	4 Homicide determined (Specify)				
6	e Hos 124 h e Fur letely		29a. Certifier (Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation.	irred at the time, date and place, an	d due to the cause	e(s) and manner as	stated. to the cause(s)
ΟX	Division  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: completely filled in by the f	Medical	and manner stated.	29c. License number			(Month, Day, Year)
9		Σ	29b. Signature and title of certifier	O.C.M.E.		June 22, 200	
				U.C.IVI.E.		Julie 22, 200	
			30. Name and address of person who completed cause of death (Item 23a)	1 Penn Street, Baltimore, N	MD 21201		
	S Regis	tate trar	31. Date filed (Month, Day, Year)  31. Registrar's Signature				
	70912	-	TOTAL CONTRACTOR OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPER				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:33 A.M 26 JUNE 2009 Wheat. Virginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Social Security Number **Funeral** 09/14/1917 Hours Days Months 1 □ M 2 🗹 F Maryland Yrs. 219-03-0046 91 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show or than "natural", or items 23a or 28a-f show 1 TXYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21213 2508 Erdman Avenue Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Exeminer material. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. Yes. Give Specify White 3 X Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberta Evans William P. Tuerke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Erdman Avenue, Baltimore, MD 21213 David W. Wheat, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Moreland Memorial Park 06/30/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. algoration 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LOBAR PNEUMONIA WEEK MULTI disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an autopsy certificate ! 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Box 68760, pe P.O. | of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. Division

Baltimore, Maryland 21215-0036

6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

29a. Certifier

(Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of certifier

29c. License number D47123 29d. Date signed (Month, Day, Year) HOSPITAL

BALTIMORE MOZIZIE

Iress of person who completed cause of death (Item 23a) (Type, Print) UMION MEMORIAL PUTHUMANA

UNN. PKWY. 201 E.

Registrar

Medical

31. Date filed (Month, Day, Year)

			For	State of Maryland	d / Depa	artment of H	ealth and N	lental Hygien	e o o o o	00016
		_	State Registrar		Cei	tificate of L	Death	Reg. N	2009	20910
	Physicia	an	Decedent's Name (First, Middle, Last,						ay Year	3. Time of Death
	/Medic	al	Warren J. Wooden  4a. Facility Name (If not institution, give	street and number)		4b. City. Town, or	Location of Death	June 21	2009 c. County of Death	5:00 p. "
<i>*</i>	Examin	er	Blue Point Nursin			Baltin			N/A	
	Funeral			7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	r) Cou	place (State or Foreign intry)
	Director		217-78-6273	52	Yrs.			July 27,	1956 Mar	ryland
land	A H		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Many	Belli	tor	Maryland N/A	Mt	. Wash	ington				1 ☐XYes 2 ☐ No
ith the	or 28 26 not	Director	10e. Street and Number			10f. Zip Code		10g. C	citizen of What Cou	intry?
ath w	23a		1801 A Thornbury	Road  12. Was Decedent Ever in U.	C 12	21209			nited Sta	
fter de	r item	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Å		Was Decedent of H f Yes, specify Cuba		Rican, etc.)	Black, White	
:1215-0036 within 72 hours after death with the Maryland	Fant, o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1□Yes 2X No	Specify:		Specify: Wh:	
5-0 12 h	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	dent's Usual Occup kind of work done of DO NOT use retired	duning most of world	ang 16b.	Kind of Business/I	ndustry
Z jā	than	фшо	Elementary/Secondary (0-12) None	College (1-4or 5+)		mployed	,	D	ependent	
	other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Maid	en Sumame)	
Xad pm	Menta arked atic e	10	Joseph E. Wooden,					ia Wronka		
Maryland 21215-0036	h and 7 le m traum		19a. Informant's Name/Relationship (T) Diane W. Thanner	урө, Print) (Sister)		•		ral Route Number, City Snellvil		
<b>6</b> , 1	Healt tem 2 other		20a. Method of Disposition	·	- Charles Committee	esition (Name of matory or other place			Location - City or	
mo Pages	Department of Health and Mental Hygiene. Important; or Iteme 23a or 28a-f show Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Mudical Examinar must be notified at once.		ty□ Burial 2 □ Cremation 3 □ I □ Donation 5 □ Other (Specify,	removal from State		matory or other place m Cemete:		/2009 Ba	ltimore,	Maryland
Baltimore, permit. Pages 1 ar	Departm Importa any Inju		21. Signature of Funeral Service Licens		2 T	2. Name and Addre	ss of Facility Funeral	Home of Du	ndalk, I	nc.
00 8	9 E 2 9		1)000	. Cell	1.7	922 Wise	Avenue	Dundalk, M		
			23a Part Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final					HARY K	V	Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	aDue to (or as a conseq		ia ai	( <del>-</del>	Abici		
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68 rtificat	ing ph) s as th		IF FEMALE:				<u> </u>			
I <b>Records, P.O. Box 68</b> The law requires that the death certifica	been signed by the attending ph should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 gonths?	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	I déath 3[	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of del Month	ivery Day Year
O all	y the a	ysic	1 Yes 2 No 9 Unknown	9 Unknown	eau st	_ Cities (specify) _				
s that	ned b	by Pr	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord:	en sig							1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records, to Attending Physician: The law requires t	8 0	Completed						24a. Was an autopsy	24b. Were au prior to death?	topsy lindings available completion of cause of
<u>ت</u> ت	certificate rector, pag		11				6:	pertormed 1 □ Yes 2	No 1 ☐ Yes	20 No
of Vital Physician:	s certi	To Be	25. Was case referred to medical examiner?  1 Yes No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Ott		ath <i>(Check only</i> one) Iome 5□ Residence	6 ☐Other (Spe	cify)
10 E	h. After this funeral di		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	ol 28c. Injui Wo	ry at	28d. Describe how in		
Vision	tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injury. At h	ome larm o		Yes 2 □ No	28l. Location (Street	and Number or Ri	ural Route Number,
Divi	offer of Direct of in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	reet, factory, office		City or Town, Si		1 2 7 10 dio 1 1 di 110 di 1,
Di Hospital or	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		vsician: To the best of my kno iner: On the basis of examina and manner stated.						
To the	within To the comple	Me	29b. Signature and title of certifier	R Gl	en	29c. Licens	se number	29d.	Date signed (Mont	1
Λ	J		30. Name and address of person who o		n 23a) (Type		ر ( ال	30	212	159
2	V	ite	31. Date liled (Month, Day, Year)	32. Registrar's Signa	146	(GH		an 6.	412	()
ok. v.	Regist		JUN 3 0 2009	Deneway B.	garke					

09-05073 Donna White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day June 27, 2009 Physician/ 0804 hrs White Medical Examiner Donna c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 57 South Carrollton Avenue 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Country) **Funeral** Min. Days Hours 2 X F Director January 25, Tennesee 218-58-8274 55 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 1 Yes 2 X No Dundalk Maryland Baltimore or items 23a or 28a-f show must be notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21 222 252 St. Helena Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married 1 Never Married XNO Yes White Specify: Yes 2 X No specify: Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after of
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or
injury or other traumatic event, the Medical Examiner m Divorced If Yes, Give Year Widowed ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) fed Elementary/Secondary (0-12) College (1-4 or 5+) Complet Own Home Housewife 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Conley Clarence Oliver Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဥ 2083 Larkhall Road, Dundalk, Maryland Brian Hylton SOR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition June 29, crematory or other place) Burial 2 X Cremation 3 Removal from State 2009 Maryland Bayview Crematory Baltimore, Donation 5 Other Specify. 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, 21. Signature of Funeral Service Licensee Dundalk, Md. 7110 Sollers Point Road, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician 'Leical Between Onset and failure. List only one cause on each line. Death Mixed drug (Cocaine, morphine & Doxepin)

Due to (or as a consequence of): intoxication Immediate Cause (Final disease aminer or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 23a,27,28a-f,perME, g893 //23/09 TT Physician/Medical X UNPENDED attending physician for use as the burial -The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 🗸 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the bed be detached Records, P.O. Yes 2 No 3 Probably 4 V Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an certificate has been setor nage 2 should prior to completion of cause of death? autopsy performed? 1 V Yes No ✓ Yes 2 page 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Division of Vital Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: DOA ER/Outpatient 3 Inpatient 2 this 1 ✓ Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After t 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: unk Yes 2X No Natura 5 Pending Director: d in by the f Fd 0800 hrs Fd 6/27/09 28f. Location (Street and Number or Rural Route Number, City or Town, State) 57 S. Carrollon Av 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc XCould not be 3 Suicide (Specify) residence Baltimore, determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptifie June 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. 31. Date filed (Month, Day, Year, State Registrar DONE

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 2009 26 FRIEDA WASSERMAN **0800** M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS 8. Date of Birth 10/26/1911 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Months Days Hours Min. 1 □ M 2 🗶 F 97 215-01-1969 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 No OWINGS MILLS BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 ATRIUM COURT USA 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 □Yes 2 No Specify 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NATHAN KAPLAN JENNIE UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD WASSERMAN / 2 HIGH STEPPER CT, #505, PIKESVILLE, MD 21208 SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PETACH TIKVÁH CEMETERY 06/28/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final teavs disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Be Completed

ဥ

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Institution of items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examiner invast be notified at once.

Exami Physician/Medical þ Be Completed Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran After this certificate has been signed by the funeral director, page 2 should be detached ours after death.
neral Director: / 24 hours a within 24 hor To the Fune completely fi

							performed?	death?
25. Was case referre	ed to medical					26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 🔼	No	Hospital	: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	3 🗆	DOA Other: 4 Nursing H	lome 5 ☐ Residence 6	SOther (Specify) ALF
27. Manner of Death 172 Natural 2 ☐ Accident	5 ☐ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e.	Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	et, facto	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only	Certifying Ph	ysician: niner: Or	To the best of my known the basis of examina	owledge, death ation and/or inve	occurre estigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)

29b, Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MD

D37573

Reisteurt

76, 7009

30. Name and address of person who cometed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd #1 per MD 9892 6/30/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Elik Zolotuskiy Day Month 09:15 AM **Physician** ZOLOTUSKEY 28 06 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 2 M 2 □ F 04/20/1916 217-35-6933 93 UKRAINE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 2434 W. BELVEDERE AVENUE 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 h Elementary/Secondary (0-12) College (1-4or 5+) SUPPLIER T00LS permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important; If fem 27 is marked other the any injury or other trauments. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHAIM ZOLOTUSKIY TOYBA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 GILLINGHAM CT., OWINGS MILLS, MD 21117 VICTORIA SERY / GRANDCHILD 20b. Place of Disposition (Name of OHEBete SHANTOM or other place)
MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State REISTERSTOWN, MD 06/29/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician TERMINAL DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PARKINSONS DISGASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the I nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year for Day 4□Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably #☐Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide ō Hospital Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN 00064533 06-19-2009

State Registrar

DHMH 17 Rev 1/2001

BARATUNDE

31. Date filed (Month, Day, Year)

2434

W. BELVEDERE

ATRIC CTR. AVE-BALTIMORE MID 2/2/5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVIN SALE GENEATCHIC

AJANI

32. Registrar's Signature

			State of M	aryland / [	Depa	artment of H	lealth and N	lental Hy	giene		
			1 - State Registrar		Cer	rtificate of L	Death		Reg. No. 2	9	20920
	Physici	an	1. Decedent's Name (First, Middle, Last)	1- 1	1	,		2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		GENEVIEVE	<u> </u>	R	NN		06		09	11:35pm
74 5	Examir	ner	4a. Facility Name (If not institution, give street and number	/		- /	Location of Death		4c. County	of Death	
arist.				rouse		THARIU If Under 1 Year	OOD M		A. A	o Distan	(0)
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last bir	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D	ay, Year)	9. Birthp Cour NY	lace (State or Foreign ntry)
	Director		Usual Residence of Decedent					06-1	1-1917	141	
2	or set		10a. State 10b. County	10c. City, Tow	n or Lo	cation			44.8	1	0d. Inside City Limits
M	a-f st	ctor	MD PG	Bo	wie						1 ∐Yes 2 <b>x∏t</b> No
ţ	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Cour	itry?
4	23a ist b		1610 Excaliber Blvd. Apt.	403			20716		US	A	
200	er m	Funeral	11. Marital Status 12. Was Decedent Armed Forces'	?	13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or N	o- 14. Raci	e - Americ	an Indian,
within 72 hours after death with the Mandaco	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'te Medical Evaminer must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ If Yes, Give	No	1	I∐Yes 2∏XNo	Specify:	, , , , , ,	Specify		White
22 hours of	ura		3€Widowed 4 Divorced Year or Dates:	1.0							
3 5	i u	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	(Give	tent's Usual Occupa kind of work done of OO NOT use retired	furing most of work	ing	16b. Kind of Bu	siness/in	dustry
with .	thar	E C	Elementary/Secondary (0-12) College (1-4or	5+)	L	Sales	,		Ret	o i 1	
1 2	Hygi other ent,	BeC	17. Father's Name (First, Middle, Last)			Dares	18. Mother's Name	e (First, Middle			
	dental rked o tic eve	To B	Michael Bonuso				E15	izabeth			UNK
<b>7</b>	is marked or aumatic ev	<b>_</b>	19a. Informant's Name/Relationship (Type. Print)	19b	. Mailin	g Address (Street a	and Number or Rui	al Route Numb	er, City or Town,	State, Zip	Code)
, IVIA	alth a		John Arnn Jr. Son	1:	218	Grove Av	e. Shac	ly Side	, MD 207	64	
בי בי בי	Department of Health and Mentition Important: If item 27 is marked any injury or other traumatic evence.		20a. Method of Disposition	l comoto	f Dispos	sition (Name of natory or other place	e) !	Date	20c. Location -	City or To	wn, State
rmit Pades 1 au	ant: h	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Hi]	ll Cemete	ry 6/10	)/2009	Suitla	nd, 1	4D
	aparti porti ny inj		21. Signature of Funeral Service Licensee		22	. Name and Addres	ss of Facility Han	desty	Funeral	Home	P.A.
פֿ נ	(0 <b>= % 3</b> )	0 9	170 d. Ju		1	2 Ridgel	y Ave. A	nnapol	is, MD 2	1401	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	the death. Do	not ente	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	BREAS	1						Onset and Death
	Medical xaminer		resulting in death)  Due to (or as	a consequence	of):						
	Adminici	_	Sequentially list conditions, b.							- 1	
ted,	ısıt	Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	a consequence	of):						
y xecu	and al-tra	xar	triat initiated events	a consequence	of):						
cate be executed	physician and the burial-transit	dical E									
		edic	u								
ath cert	andin use a	sician/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant		• -				23d. Dat	e of delive	ery
deat	e attr	icia	1 Ves 2 No 4 Pregnant	2 ☐ Fetal death at time of death		Ectopic pregnancy Other (specify)			Mo	nth	Day Year
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es th	igned be de	by F	Part II. Other significant conditions contributing to death b	ut not resulting in	the un	derlying cause give	en in Part I.	23e. Did			ne cause of death?
law requires t	een s oould	ted						1 🗆	Yes 2 No	3 ☐ Prob	oably 4 Unknown
aw	as b	Completed						24a. Was		Vere auto	psy findings available mpletion of cause of
The	cate,	Sol						perfe 1 □ Yes	ormed?	leath? □Yes	
ician	certifi	Be	25. Was case referred to medical examiner?			0.15	26. Place of Deat	h (Check only	one)	MA	NARIN
Phys	this ral dir	<u>د</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpati 27. Manner of Death 28a. Date of Inj	ent 2 ER/Ou	tpatien		T I Nullaing Fic			er (Specif	in Hospet
Attending	h. After funer	tion	1 → Natural 5 → Pending (Month, Da		njury	28c. Injury Work	rai ? res 2 □ No	28d. Describe	how injury occurre	∌a	TOULV
tten	deat ctor: y the	fica	2 Could not be	urv - At home, fa	rm. stre		162 5 140	28f Location	Street and Numb	er or Rum	I Route Number
lo	after   <b>Dire</b> d in b	Certification:	4 Homicide determined building, el	ury - At home, fa c. <i>(Specify)</i>	,	ou, radion, james			wn, State)	or ridic	a riodic riambei,
spita	hours ineral y fille		29a. Certifier 12 Certifying Physician: To the best	of my knowledge	e, death	occurred at the tin	ne, date and place,	and due to the	cause(s) and ma	inner as s	tated.
oH et	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examiner: On the basis of any manner st	of examination an	id/or inv	estigation, in my op	pinion, death occur	red at the time	, date and place, a	and due to	the cause(s)
Tot	To tl	Ž	29b Signature and title of certifier			29c. License	number		29d. Pate signed	(Month,	Day, Year)
		1	JUNY JOHN	4		(~	PC PIN. 1		Min	e 10	2009
1	407,0	N	30. Name and address of person who completed cause of		Type, F	Print)	< Aren	WA.	ANNAPUL	0 W	12 2/4/)1
	120		31. Date filed (Month, Day, Year) 32 Registr	rar's Signature	I U.	16/6/02	t 1147)	7/	, , , , , , , ,	7 4.	7 71 701
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Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and

			Please	Type or Print in I				_	_	ible.		
			1 - For State Registrar	State of Marylar		ertificate of		-	giene Reg. No. 🤈 [	000	20021	
			1. Decedent's Name (First, Middle, La	st)				2. Date of De Month		Year	3. Time of Death	
	Physicia /Medic		THOMAS CLIFTON		•			MAY 12	, 2009	2009 4:14 A M		
	Examin	ner	4a. Facility Name (If not institution, given 11203 MAIDEN DRI			4b. City, Town, o	r Location of Death F.		PRINC	y of Death E. <b>CEO</b> I	PCF ! S	
	Funeral		Social Security Number     6. 8	Sex 7. Age (In yrs.	last birthday		If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da 05-13-1			olace (State or Foreign	
	Director		577-40-4560 Usual Residence of Decedent	10 m 2□ F   78	Yrs.	Months Days	110010	05-13-1	1930	Wash	.,D.C.	
	ryland how		10a. State 10b. County	10c. Ci	ty, Town or L	ocation			-	1	10d. Inside City Limits	
	ne Mar 18a-1 s ouified	Director	Maryland Prince G	eorge's		Bowi	е		10 011	145	⊅∰Yes 2 □ No	
	with the		10e. Street and Number 11203 Maiden Dri	110		10f. Zip Code 2072	n		10g. Citizen of	SA	ntry?	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	. Was Decedent of H		ecify Yes or No		ce · Ameri		
20	or ite	by Fu	1 ☐ Never Married 2 ☑ Married	1 Yes 2 No If Yes, Give Year or Dates: 1952		1 ☐ Yes 2 No		Hican, etc.)		ack, White, ify: B1a		
2-003p	2 hours atural		15. Decedent's E	ducation	16a. Dece	edent's Usual Occup	pation		16b. Kind of I			
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7	lled wi Hygier ther th		17. Father's Name (First, Middle, Last	1-4	110	all Callie	18. Mother's Nam	e (First Middle			Service	
yıand	ld be f lental ked o ic eve	To Be	Thomas C. Anders					Cloe	,	,		
Mary	2 shou and N Is mai	-	19a. Informant's Name/Relationship			ling Address (Street						
e,	1 and 3 Health em 27 ther tr	0.	Joan D. Anderson/ 20a. Method of Disposition			Maiden I		owie, Ma	aryland 20c. Location			
	Pages ent of I nt: If Ite y or o'		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Hemovai from State		osition (Name of ematory or other place Memorial (						
Баншог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	nsee		22. Name and Addre		2007	Juleiun	<b>a,</b> 11 <b>a</b> .	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	h. Donoter	nter the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Arrhythmia  Due to (or as a consequence)	uence of):							
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Ď,	e exectanal	Exa	resulting in death) Last	Due to (or as a consec	uence of):							
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Š	n certii ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta		☐ Ectopic pregnanc			23d. D	ate of deliv	ery	
<u> </u>	ne deat the att hed for	Physician/Medica	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)	, y		\ \ \	1onth	Day Year	
L	that the		Part II. Other significant conditions	contributing to death but not res	ulting in the i	underlying cause giv	en in Part I.	23e. Did 1	tobacco use co	ntribute to t	he cause of death?	
cords,	equires en sign ould be	ed by	Hypertensive Ca	ardiovascular	Diseas	se		1 🗆	Yes 2 □ No	3□ Pro	bably <b>दिं</b> Unknown	
) )	has be	Completed						24a. Was	DSV	prior to co	opsy findings available ompletion of cause of	
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<b>S</b> :	iysicia iis cert directo	o Be	examiner?  1 \( \text{Yes}  2 \( \overline{\text{M}} \) No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA Oth	26. Place of Deat ler: 4 □ Nursing Ho			ther (Speci	ify)	
5 1	Ing Ph	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	ry at k?		how injury occu			
2	death death ctor: / y the f	ficati	2 Accident investigatio 3 Suicide 6 Could not b	e 290 Place of Injury At h	ome, farm, st		Yes 2 □No	28f. Location /	Street and Nun	nber or Run	al Route Number,	
3	tal or / s after al Dire ed in b	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	, , , ,		City or To	wn, State)		,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 CertifyIng Pl (Check only one) 2 Medical Example 1	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, dea ation and/or i	ath occurred at the ti investigation, in my o	me, date and place opinion, death occur	, and due to the red at the time,	cause(s) and date and place	manner as e, and due t	stated. to the cause(s)	
; I	vithi To th	ğ	29b. Signature and title of certifier	/2/		29c. Licens			29d. Date sign	ed (Month,	Day, Year)	
			20 Name and Add			MD121	J4 		06/09	1200	09	
,	5		30. Name and address of person who Patricia Davidso	on, MD 106 Ir	ving S	t.,N.W. S	uite 118	Wash.,	. б.с. 2	20010		
	Sta Registra		31. Date filed (Month, Day, Year)	82. Registrar's Sign	ature for	plas						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1252 M 2009 Charleen Ann Butts /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. 1 □ M 2 🖸 F Months Days Hours Sept. 10,1938 Maryland 219-34-5659 Director 70 Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It we Medical Examinar must be notified at 1 X Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21740 Funeral 112 East Antietam Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 📉 No Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Helen Gruber Charles Leroy Stumbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Wishbone Circle Hedgesville, WV Tony Butts 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenlawn Mem. Park June 20,2009 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility sborne Funeral Home P.A. 425 S. Conococheague St. 21 Sign have of Funeral Service Licens, e Williamsport, Maryland 21795 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pich line. Immediate Cause (Final **Physician** Dulnovan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

-4 the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to dealingut not resulting in the underlying cause given in Part I. þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **DN** 1 □Yes 1 ☐ Yes 2 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ EF/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANCISCO L. Day, Year) State JUN 19 Registrar

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.
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			Plea	ase Type or Pri							_				
			for State	State of M	aryland		artment of I <i>rtificate of</i>	Health and M							
			Registrar  1. Decedent's Name (First, Midd	lle, Last)		Cel		Dealii	2. Date of Deat	e <b>g. No</b> . h	2005	3. Time of Death			
	Physici		Geraldine		B1ur	me		Month June 1	Day	/ Year 2009	6:37 A M				
	/Medio		4a. Facility Name (If not institution	)	Dia		or Location of Death	oune_n	7	County of Death					
, A			13206 Willia	ms Road			mberland			A11	egany				
	Funeral		5. Social Security Number		ge <i>(In yrs. la</i> 2 0		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/17/1	Year)	Cou	place (State or Foreign ntry)			
١.	Director		212-18-1917   1 M 2 M F   88 Yrs.   Months Days Hours Min.   04/17/192									I WV			
e Ca	NOW ME		10a. State 10b. County	,	10c. City,	Town or Lo	cation					10d. Inside City Limits			
Mar	s -e	ctor	MD A1	legany		Cum	berland					1 ☐ Yes 2 🙀 No			
th th	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citi	zen of What Cou	ntry?			
t d	s 23a		13206 Wil	lliams Road				21502			US				
a ra	item	Funeral	11. Marital Status	Armed Forces?			Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Ameri Black, White,</li> </ol>				
)36     	o,"	by F	1 ☐ Never Married 2 ☐ Mar 3 🛱 Widowed 4 ☐ Divorced	If Voc Give	NO		1 □Yes 2 📉 No	Specify:			Specify:	White			
?1215-0036 within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show	ted	15. Deceder	nt's Education	I	16a. Dece	dent's Usual Occu	pation		16b. Ki	nd of Business/Ir				
Z diff	le.	Completed	Elementary/Secondary (0-12)	College (1-4or	College (1-4or 5+)			during most of worki	ng						
N C	tal Hygiene. d other than "naturevent, II.» Musical	S	12	1		F	hlebotom		VE: A 44:41		Hospi	tal			
yland yldbe file		Be	17. Father's Name (First, Middle, Winfield	, Last) Sco	++		Grav	18. Mother's Name Bertie	e (First, Middle, I	naiden	Beal	1 1			
	and Mental is marked o	ျ	19a. Informant's Name/Relations			10h Mailir		t and Number or Rura	al Pauta Numbo	Cityo					
<b>E</b> S			Sharon Twigg/				-	ms Road,							
-υ υ	item othe	-	20a. Method of Disposition		20b. Pla		sition (Name of natory or other pla				ocation - City or To	own, State			
E Page	Department of Important: If its any injury or o		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5					ark   06/18	/2009	Cu	umberlan	d. MD			
alt	Departr Importa any inju		21. Signature of Funeral Service	Licensee	/	1		ess of FacilityAdan		-		Home, P.A.			
מ נג	10 E # 9		P CKILL O	NUOLUNG		4	04 Decati	ur Street,	, Cumber	lan	d, MD 2	21502			
			23a. Part En Le disease, o shock, or heart failure. Lis	r complications that caused t only one cause on each ii	d the death. ine.	Do not ent	ter the mode of dyi	ing, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death			
	nysician		Immediate Cause (Final disease or condition resulting in death)	-a Con	resti		Heart	railure	2			Loweeks			
	Medical xaminer		, cooking in doda,	Due to (or as	e conseque	ence of):	andra	mariant	R			2			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	-	ence of):	ururo	rryopest.	7			o years			
cuted	nd ransit	Examiner	Cause (Disease or injury that initiated events	<b>S</b> .											
οU, be exe	ian al urial-t	al Ex	resulting in death) Last	Due to (or as	a conseque	ence of):									
<b>56/</b> C	ohysic the b	dica		d						_					
X o	ding   Se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	CV									
<b>BOX</b> leath cel	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal o	death 3[	☐Ectopic pregnand ☐Other <i>(specify)</i> _	су		1 2	23d. Date of deliv Month	very Day Year			
je je	by the	Physician/Medica	1 □Yes 2 □No 9 □ Unknown	9 🗆 Unknown			_ Caror (opecary) _								
S, T	gned e det	by P								ise contribute to	ontribute to the cause of death?				
ecords, law requires t	sen si ould t								1 □ Ye	s 2[	∏ No 3 <b>⊠</b> Pro	bably 4 Unknown			
	as be	Completed							24a. Was a		24b. Were auto	opsy findings available ompletion of cause of			
The	cate;	Co							perforr 1 ☐ Yes	ned? No	death? 1 □ Yes	2 <b>K</b> No			
VII.	certif	Be	25. Was case referred to medica examiner?	Hospital:			Ott	26. Place of Death							
2 ਵੁੱ	er this	<u>ان</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ury 2	28b. Time of	28c. Inju	ry at	me 5 Reside		6 ☐ Other (Speci	ify)			
ding	ath. r: Afte e fun	atio	1 △ Accident 5 ☐ Pendir	ng (Month, Da	ay, Year)	Injury	Wor	rki? ]Yes 2 □ No			,				
VIS r Afte	recto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	in a lace of Ini	jury - At hom tc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St City or Town			al Route Number,			
2 §	rrs aft ral Di	Cer													
Hosp	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 \(\overline{\text{V}}\) Certifyi (Check only one) 2 \(\overline{\text{Medical}}\) Medical	ng Physiclan: To the best Examiner: On the basis of	of examination	ledge, deatl on and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) ate and	) and manner as I place, and due t	stated. to the cause(s)			
o the	orthin S	Med	29b. Signature and title of certifie	and manner st	ated.		29c. Licens	se number	2	9d. Dat	te signed (Month,	Dav. Year)			
μä N	11		+ taul T	· Mureron	m	Λ	D23				June 16,				
7	+		30. Name and address of person	who completed cause of c	death (Item 2	23a) (Type,	Print)								
Ì	YRS		Pau	l T. Livengo	od, M	.D.,	912 Set	on Drive,	Cumberl	and	, MD 21	502			
	Sta Registra		31. Date filed (Month, Day, Year)	2009 Serens	rar's Signatu	bar	Led .								
	negistr	aı	7011 - 1 1	Here	1	1									

			_ FOI	epartment of Health and N Certificate of Death	Mental Hygier		00001
H	Physici	an	1. Decedent's Name (First, Middle, Last)	or mode or bodin	2. Date of Death	2009 2009	3. Time of Death  11:45AM
	/Medic Examin		Alan Wirth Baumgardner  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	11.4JA
	LX	Ci	5425 Jefferson Blvd.	Frederick		Frede	rick
ē	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−3028 7. Age (In yrs. last birtho 78 Yrs. 100−24−24−24−24−24−24−24−24−24−24−24−24−24−	Months Days Hours Min	8. Date of Birth (Month, Day, Yea 3/8/193	1 9. Birthp	ace (State or Foreign try) York
	land ow t		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of the county	r Location		1	0d. Inside City Limits
	Mary a-f sho ified a	ctor	MD Frederick Fre	ederick			1 ☐ Yes 2 XNo
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 5425 Jefferson Blvd.	10f. Zip Code 21703	10g. (	Citizen of What Coun	try?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Married  1 Never Married  2 Married  1 Never Married  1 Never Married  2 No 1949 - If Yes, Give Year or Dates: 1951	13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puert 1 Yes 2X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
	d within 72 ho giene. er than "natul the Medical"	Completed	(Specify only highest grade completed) ((	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) DOR relations	rking   N	ational ng Corp	Broadcas
pu	be file ntal Hy id othe event,	Be	17. Father's Name (First, Middle, Last)		ne <i>(First, Middle, Maid</i> Frances W		
Maryland	hould nd Mer marke matic	2	Henry Clay Baumgardner  19a. Informant's Name/Relationship (Type. Print)  19b. N	lailing Address (Street and Number or Ru			Code)
Ma	ind 2 salth ar 27 is			25 Jefferson Blv			
ore,	of Her of Her if Item or othe		1 Paural 2 Micremation 13 Hemoval from State 1	isposition (Name of crematory or other place)		Location - City or To	
Baltimore,	t. Pag rtment rtant: I		Other (Specify) Smith:	sburg Crematory6			
Ba	perm Depa Impo any i	1	21 Strature of Furfixed Fervice Lic In en	22. Name and Address of Facility Donald B. Thomp POB 18, Middlet	son Fune	ral Home	
	Physician		29a. Part1 Enter the disease, or complication, that caused the death. Do not shock, or heart failure. List only one cause or each line. Imme The Cause (Final disease or condition	enter the mode of dying, such as cardiac	c or respiratory arrest,		Approximate Interval Between Onset and Death
.00	Medical Examiner bhysician and the burial-transit	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Last  Last  Lue to (a as a consequence of)  Due to (or as a consequence of)  C.  Due to (or as a consequence of)				10 yrs.
.O. Box 68760,	eath certifi attending for use as	Physician/Medical	d	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
S, P	es thai igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	\ /	co use contribute to the	
Division or Vital Records,	The law requires that the disare has been signed by the page 2 should be detached	Completed			24a. Was an autopsy performed	24b. Were auto prior to co death?	pably 4 Unknown psy findings available mpletion of cause of
ital		a)	25. Was case referred to medical examiner?	26. Place of Dea	1 Yes 2 ath (Check only one)	No 1 ☐ Yes	2 No
on or V	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, I	ion: To B	1		dome 5 Residence 28d. Describe how in	e 6 □Other (Specifinjury occurred	(y)
Divisi	al or Atten s after deat il Director: id in by the	Certification:	Accident  3 Suicide  4 Homicide    Could not be determined   See Place of injury - At home, farm building, etc. (Specify)				
	Hospit 4 hours Funera tely fille		29a. Certifier (Check only Medical Examiner: On the basis of examination and/	teath occurred at the time, date and place or hivestigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	ro the vithin 2 ro the comple:	Medical	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			> Nobby La Landonson	J-1397	/ 6	15/09	<b>L</b>
~	14+1		30. Name and address of person who completed cause of death (Item 23a) (T		0.1.7.0.1		
B	Sta	to	Robert L. Kaufman 300 W. Ninth S	St. Frederick, Md.	21701		
	Regist		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature 32. Hegistrar's Signature	bake			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** David R. Brosnahan, Sr. 10:35 AM June 9, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b City Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 12**€3**MM 2□ F Director 579-68-7787 10-05-1951 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be realised at Funeral Director 1 Tytes 2 □ No Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21401 843 Boatswain Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 □ THE If Yes, Give Year or Dates: Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Washington Post Circulation Supervisor h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Reidy James Joseph Brosnahan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is 20715 3827 Winchester Lane, Bowie, MD Edward J. Brosnahan/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition jo := ō Nurial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Department of Important: If any injury or once. Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 6/13/2009 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee - Free You 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Obstuctive Lung Disease > lyeer disease or condition resulting in death) propic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2" to lung transplant is jectury 1 ✓ es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐Yes 2 ☐No 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28h Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

P.O. Box 68760,

of Vital Records,

Division

State Registrar 29b. Signature and title of certifie

Ruboit Peterson mo AAMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

29c. License number 02408

Annapolis MD 21461

29d. Date signed (Month, Day, Year)

6-9-2009

09-0489	0
Deana B	utler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Jeana Dutier		1- For State	State of Maryland	-	tificate of		ila Meritai		eg. No.	19 2092
Physicia	in/	Registrar  1. Decedent's Name (First, Mi						Date of Dea     Month	ith Day Year	3. Time of Death
Medical Exami	ner	Deana E	Butler			In City Town	or Location of D	June 20, 2	2009 4c. County of Dea	2045 hrs
) 		Baltimore Washing	on Medical Center			Glen Burn	ie		Anne Arunde	1
Funeral Director		5. Social Security Number 214–94–8086	1 M 2X F	ge (In yrs. Ia 41	ast birthday) Yrs.	If Under 1 You Months Da			21, 1967 Fore	irthplace (State or ign ountry) Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. Cour	ity	10c. City,	Town or Locati	on				10d. Inside City Limits
laryland Sa-f show at once.	ģ	MD Anne Arundel Glen Burnie						<u></u>	O. Oiling of Milest Co	1 Yes 2 X No
h the Mary 3a or 28a iotified at	I Director		ue SE Second			10f. Zip Code 210	61		USA	
15-0036 filed within 72 hours after death with the Maryland Hygiene. 4 other than "natural", or items 23a or 28a-f sh. 5, the Medical Examiner must he notified at once	y Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 X	1 Yes 2 Divorced If Yes, Give Year		If Y		an, Mexican, Pu	' ( Specify Yes or No ierto Rican, etc.)	White, etc.	rican Indian, Black,
lours a	bg pa	15. Decedent's Education (S	Lor Dates: pecify only highest grade cor	npleted)			pation (Give kind		16b. Kind of Business	s/Industry
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	Elementary/Secondary (0-1		5+)		3artende	er		Various	Bars
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Mid- Ernest G. But						lame (First, Middle, I aleen Wari	•	
re, MD 21. I and 2 should be Health and Men fitem 27 is mar or traumatic eve	P	19a. Informant's Name/Relation Cathaleen But							nber, City or Town, Sta ${ m lvd}$ . Arnol	te, Zip Code) .d, MD 21012
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental lant: If item 27 is marked or other fraumatic event,		20a. Method of Disposition  1 Burial 2 Crema	tion 3 Removal from S	ate	Place of Dispos rematory or oth	ition (Name of oner place)	cemetery,	Date June 25,	20c. Location - City of	or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other 21. Summure of Funeral Serv		At		Cremato		2009 ·	Glen Bur	nie, MD Funeral Hom-
	4	23a. Part I. Enter the disease	or complications that caused	the death			SS of Facility Sons, Ritchie		verna Park,	MD 21146 Approximate Interval
Physician /Medical xaminer		failure. List only one cau Immediate Cause (Final disea or condition resulting in death	use on each line. ase a Methadon	e int	oxicat		9, 000.700 00.0			Between Onset and Death
		Sequentially list conditions, b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate	se d							
cuted and transit		events resulting in death) La	d.				000/	0/21/00 m	<u> </u>	
760, fcate be executed physician and the burial - transit	Medical	X UNPENDED	, willinger			per, M	E G894 8	8/31/09 T'	23d. Date of delive	
x 68 h certif tending use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 ✓	4 Pregnant a		2 Fe	tal death 3	B Ectopic pr	egnancy	Month	Day Year
P.O. BO:	by Ph	Part II. Other significant con		h but not re	esulting in the u	nderlying cause	e given in Part I		obacco use contribute t	
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should be	Completed	-	,					autop perfo 1 ✔ Yes	ormed? death?	
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to med examiner?	Hospital: 1 🗸 Inpatie		5510 4 41 4		Other	neck only one) ursing Home 5	Residence 6 Oth	
of Viing Phys	٦ ا	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	ury	ER/Outpatient 28b. Time of I		njury at Work?		how injury occurred	
ion ttendin leath. tor: A	atio		ending (Month, Day, vestigation Fd 6/20		Fd 8:30	) pm <sup>1</sup>	Yes 2X No			
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	Accident Solution (Street and Number or Ryral or Town, State) 110 5th Av Specify)  Accident Solution (Street and Number or Ryral or Town, State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av State) 110 5th Av								Rural Route Number, City Ave SE Apt
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To To	Med	29b Signature and title of cer	and manner stated tifier			29c. Lice	nse number		29d. Date signed (A	fonth, Day, Year)
		Wayante	MeGhele			0.0	C.M.E.		June 21, 2009	
		30. Name and address of personal Margarita Korell MD	·			enn Street,	Baltimore, N	MD 21201		
St	~~~	31. Date filed (Month, Day, Ye	ar) 32. Registra	ar's Signatu		N.J				

			State of Maryland / Dep 1- State Amend Item 29d per dr., g892	artment of Health and N ,06/30/09dhb rtificate of Death	nental Hygie Reg.	ne No. 2	20927	
	Physicia		1. Decedent's Name (First, Middle, Last)  MARY ELIZABETH BAUCOM		2. Date of Death	Day 2009 Year	3. Time of Death 7:10P M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) GENESIS WALDORF CENTER	4b. City, Town, or Location of Death WALDORF		4c. County of Death CHARLES		
	Funeral Director		5. Social Security Number 215-88-0684 6. Sex 1 M ST F 7. Age (In yrs. last birthday 1 M ST F 1 0 0 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp 908 IOW.	place (State or Foreign	
Ī	show	'n	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or L	ocation WALDORF		1	0d. Inside City Limits 1 □Yes 2፟X No	
ild Z. I.Z. 15-0050 be filed within 72 hours after death w alla Hygiena "natural", or items 23a d other than "natural", or items 23a vvent, the Medical Examiner must i	Director	10e. Street and Number 4140 OLD WASHINGTON RD.	10f. Zip Code 20602	10g. Citizen of What Country? U.S.A.				
	rs after death v I", or Items 23e xaminer must	by Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White, Specify: WHI	etc.	
	Completed	15. Decedent's Education (Specify only highest grade completed)  [Given the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the co	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) OMEMAKER	king	o. Kind of Business/In			
	To Be C	17. Father's Name (First, Middle, Last) MILTON CAMPBELL STILWELL		ne (First, Middle, Mai				
Mary	and 2 shou ealth and M n 27 Is mai er traumat			ing Address (Street and Number or Ru 50 BELLE RIDGE		city or Town, State, Zij HESVILLE	Code) 2063	
Pages 1 and sent of Health of Health of Health of Your other try or other try	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition CEDAR H.	osition (Name of ematory or other place) ILL CEMETERY 6 –		c. Location - City or T JITLAND , M.		
Dalling	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee M00479  23a. Part1. Enter the disease, or complications that caused the death. Do not en	22 Name and Address of Facility RAYMOND FUNERAL LA PLATA, MARYLA	ND 20646		Approximate	
,no/	Physician /Medical Examiner and the prujar-transit the prujar-transit the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control of the prujar-transit control	ical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ur Heart o	disese		Interval Between Onset and Death	
O. DOX O	ding Physician: The law requires that the death certificate be executed n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deline	very Day Year	
cords, P.	uires that signed by Id be deta	Ş	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 nknown			
Ū L	n: The law reg icate has beer r, page 2 shou	Completed			24a. Was an autopsy performe 1  Yes 2	prior to death? No 1 □ Yes	topsy findings available ompletion of cause of 2 ☐ No	
or vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1	ent 3 DOA Other: 4 Nursing I		ce 6 □Other (Spec	ify)	
ISION	I or Attending Paffer death. Director: After i	ertification:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Suicide 6 Could not be determined	Work?  M 1 □ Yes 2 □ No	28d. Describe how 28f. Location (Stre	eet and Number or Ru	ral Route Number,	
2	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	4 ☐ Homicide building, etc. (Specify)  29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, de		City or Town,	,	stated.	
	the Hos hin 24 ho the Fun mpletely	Medical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	curred at the time, dat	te and place, and due	to the cause(s)	
	<b>10</b> wit		29b. Signature and title of ceptifier	Nonalde	) T <sub>1</sub> ,	me 4. 200	9	
			30. Name and address of person who completed cause of death (Item 23a) (Typ  ATUL KATYAL 6 205+ OK	e, Print)  Fix col. W	Isldont	and.	20602	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) (32. Registrar's Signature JUN 3 0 2009 Server S. Jan	Ked				

DHMH 17 Rev 1/2001

			For State Registrar		State o	of Marylan			of Health of Death			jiene leg. No. 🤉 [	1119	20928
			Decedent's Name (First, Middle, Last)								2. Date of Death		<u> </u>	3. Time of Death
	Physicia		Elmer Garland			Crov	Crowe			Day 20	Year	10:25 AM		
many.	/Medic Examin		4a. Facility Name (If not instit	tution, give	street and nu	ımber)		4b. City, To	wn, or Location	of Death	June		y of Death	
			Lions Ctr for	r Reha	ab and	Ext Car	re		Cumberla				Alleg	
	Funeral Director		5. Social Security Number 213–44–1201	6. Sex 1 [∑	( (M 2□F	7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Months [	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day 05/14/	, <i>Year)</i> 1944	Cou	place (State or Foreign ntry) vland
			Usual Residence of Deceden	nt		L								
mer 36	f show	ō	10a. State 10b. Co	<sub>unty</sub> legany	7	10c. Ci	ty, Town or Loc	cation Mt. Sa	avage					10d. Inside City Limits 1 ☐ Yes 2 ☐XNo
	n with the N 3a or 28a- st be notifi	al Direct	10e. Street and Number 16113 (	Calla	Hill :	Road, N	W	10f. Zip C	ode 215 <sup>1</sup>	<del></del>	1	10g. Citizen of	What Cou US.	-
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinant be inclifted at once.	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ 3 □ Widowed 4 □ Divo	l II	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 ሺ No <i>Specify:</i>					14. Race - American Indian, Black, White, etc.  Specify: White				
EIn 5-0036	tura stura	ed	15. Dec	edent's Edu	Year or I		16a. Deced	lent's Usual (	Occupation			16b. Kind of		
$C_{rowe}$	within 72 ene. than "na	mplet	(Specify only h Elementary/Secondary (0- 12	nighest grad	e completed,	) (1-4or 5+)	(Give life. L		done during mo retired) 'Visor	st of workii	ng	Μs	nufa,	cturing
	filed Hygi ther snt, II	ပ္မ	17. Father's Name (First, Mid	ddle, Last)			<u></u>	buper		ner's Name	(First, Middle,			Scut IIIg
	uld be Mental irked c	To B	Elmer			Crov	ve		A	dalir	ne		Bis	shop
Mary	12 shoul th and M 7 is mar traumati	ľ	19a. Informant's Name/Rela				1				al Route Numbe			ip Code) D 2 <b>1</b> 502
	1 and Health em 27 other to		20a. Method of Disposition	VC / W	11.6	20b.	Place of Dispos				ate	20c. Location		
Baltimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2 🌠 Cremat 4 ☐ Donation 5 ☐ Oth	tion 3 □ F er <i>(Specify)</i>	Removal from	i State I	mberlan	d Crem	natory (				erlan	
Balt	permit. Depart Import any Inj	l ,	21. Signature of Funeral Ser	vice Licens	oe Or No						ams Fam: , Cumbe:	-		Home, P.A. 21502
	Dhysisian	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  _a.  ARSTAM SISEASE												Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)		Due to	(or as a consec			1 14 2	) ( ) Re	TIE			,
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. <b>J</b>	b. Dilai to	oras a conse	plance of							<del></del>
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c											
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P.O. Box	or Attending Physician: The law requires that the death certific that death.  Director: After this certificate has been signed by the attending Ic in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   1 □ Live birth 2 □ Fetal death   3 □ Ectopic pregnancy   4 □ Pregnant at time of death   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   5 □ Other (specify)   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Unknown   1 □ Un								23d. Date Monti			very Day Year
	that ned by deta	y Ph	Part II. Other significant co	nditions co	ntributing to	death but not res	sulting in the ur	nderlying cau	se given in Part	1.	23e. Did to	obacco use co	ontribute to	the cause of death?
rds	w requires that the de been signed by the should be detached	q pa	CITRONIC F	Renal	1 15	REME					1□1	res 2□No	3□ Pr	obably 4 Unknown
ဝိ	law re as bee 2 sho	plet									24a. Was autop			topsy findings available completion of cause of
Ä	ician: The law certificate has ector, page 2 s	Som									perfo	rmed? 2 <b>M</b> No	death? 1 ∐Yes	
/ita	ysician: is certific director,	Be (	25. Was case referred to me examiner?	I	h 'k - 6				Otto		(Check only o			
<u></u>	Physia this c		1 ☐ Yes 2 🕅 No			Inpatient 2					me 5 Resid			cify)
ion	nding F uth. r: After e funera	ation:	27. Manner of Death  1  Natural 5 □ Pe 2 □ Accident	ending vestigation	28a. Date (Mo	e of Injury onth, Day, Year)	28b. Time of Injury	f 286	c. Injury at Work? 1 ☐ Yes 2 [		28d. Describe h	now injury occ	urred	
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	3   Suicide 4   Homicide  6   Could not be determined  28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)								28f. Location (5 City or Tov		mber or Ru	ral Route Number,
	Hospital 4 hours a Funeral I tely filled	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Certifier 29d. Certifier 29d. Certifier 29d. Signature and title of certifier  29d. License number  29d. License number									and due to the red at the time,	cause(s) and date and plac	manner as e, and due	s stated. to the cause(s)
	0 0 0	0												
	To the within 2 To the Completer	Med	29b. Signature and title of ce	ertifier				29c.	License number	-		29d. Date sig	ned (Monti	n, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

10 925 Bishop Walsh Rol. Cumber and MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harit S. Sicher 31. Date filed (Month, Day, Year) JUN 18 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . 2<u>009</u> Month 7:35 P M Carlomany June 13, Loretta Katherine 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Williamsport Nursing Home Williamsport | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10 / 22 / 19 15 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2√□ F 93 214-05-9500 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Cumberland MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 731 Gephart Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Loretta Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 722 Gephart Drive, Cumberland, MD Charles Carlomany / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State S.S. Peter & Paul Cem 06/17/2009 Cumberland, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

the Medical

7 is marked other traumatic event,

Department of Heal Important: If Item 2 any injury or other once.

Health a

Director

Completed by Funeral

Be

Examine

Physician/Medical

Completed by

Be ၉

Certification:

ical

29b. Signature and

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t as after death.

I Director: After this d in by the funeral d To the Hospital of within 24 hours at To the Funeral Completely filled it

Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditio	ns contributing to death b	ut not resulting in the ur	derlying ca	use given in Part I.		use contribute to the cause of death?	
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
25. Was case referred to medical				26. Place of De	ath (Check only one)		
examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3 🗆 DO/	Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)	
27. Manner of Death  Natural 5 Pending Accident investig			M 28	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	20e. Place of inj	ury - At home, farm, street. (Specify)	28f. Location (Street a City or Town, Stat	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
	g Physician: To the best Examiner: On the basis o and manner st	of examination and/or in				s) and manner as stated. nd place, and due to the cause(s)	

29c. License number

Ave Hagerstown MD

29d. Date signed (Month, Day, Year)

TOLS State Registrar

Mahmood 580 Northern 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** June 12. 4:34P Catherine Clark Marv /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Clinton Southern Maryland Hospital Center If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Month, Day, Year, May 15, 1933 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland 1 □ M 2 K F Months Days Hours Min. 578-44-7638 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Eventine" or the most be multipled at 1 □Yes 2√No Director Maryland Prince George's Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16607 Old Cabin Place 20607 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Ti1ch Marie Underwood ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Clark - Husband 16607 Old Cabin Place Accokeek, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If its any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State St. Mary's Church Cem. 06/18/2009 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Funeral Service Licensee 2. Name and Address of Facility
George P. Kalas Funeral Home P.A.
6160 Oxon Hill Road Oxon Hill, Maryland
20745 23a. Part / Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, Ö ۵. Division of Vital Records, 28a-f show

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Pages 1

Baltimore, Maryland 21215-0036

Physiclan: The law requires that the death certificate be executed signed by the a d be detached for should I page 2 certificate this After or Attending death. Hospital

funeral within 24 hours after death

To the Funeral Director;
completely filled in by the

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DHMH 17 Rev 1/2001

State Registrar

Medical

29b. Signature and title of certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

erson who completed cause of death (Item 23a) (Type, Print)

29a, Certifier

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Manuel Diaz June 15, 2009 09:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg 117 Walnut Street if Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days Hours Director 85 March 12, 1924 Maryland 215-20-5291 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 □ No Director Allegany Frostburg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 117 Walnut Street Items 23a U.S.A. 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 NYes 2 No if Yes, Give Year or Dates: WWII 1 Never Married 2 Married Specify: White ö 1 Yes 2□ No Specify: Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic evenonce. Maria Alvarez Candido Diaz ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21532-Darren A. Diaz 117 Walnut Street Frostburg son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 19, 2009 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEART PALLURE CONGESTIVE /Medicai Due to (or as a consequence of): Examiner ARTERY CORONARY Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 🗌 No 3 ☐ Probably 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

After within 24 hours after death To the Funeral Director:

3+

nas

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sidhu

and manner stated

Rd. CUMBERLAND, MD 21503

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

6 Could not be determined

11 grown

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20032

Physicia	į
/Medica	
Examine	

**Funeral Director** 

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modifical Examiner must be notified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit State Registrar

1 - State Registrar Certificate of Death Reg. No. 2009 2009										60706	1100
	1. Decedent's Name (First, Middle, Last)			-		2	2. Date of Dea	ath	Ye ar	3. Time of Death	
in	Elin Julia Dolan						June 1	.0, <sup>Day</sup> 2009	Teal	6:33 P M	
al er	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, o	r Location of			4c. County			
-	Anne Arundel Medical C	enter		Anna	polis			Anne	Aru	ndel	
	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		3. Date of Birt	th No and	9. Birth	place (State or Foreign	_
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	Usual Residence of Decedent						ounc 2	1,1,0,			_
	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits	
ţō	Maryland Anne Arundel		1 ☐ Yes 2 ☐XNo								
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Be Completed by Funeral Director	2622 Vantage Cove	ISA									
era	11. Marital Status 12. Was D	e - Ameri	can Indian,	-							
Ë	Armed	Forces? s 2 👿 No	10.1	Was Decedent of I f Yes, specify Cub	an, Mexican,	, Puerto Ri	ican, etc.)	Bla	ck, White,		
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	17. Father's Name (First, Middle, Last)	h			TO. WIOTHER			ia Sande			
2	Joseph Martin Bolas	11	_								_
	19a. Informant's Name/Relationship (Type. Print)			ng Address (Street						p Code)	
	George E. Dolan/ Husba			Vantage							
	20a, Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other pla	ce)	Da	te	20c. Location	City or T	own, State	
	1 ☐ Burial 2 🏿 Cremation 3 🗋 Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	III State	_	rematory		5/11/	09	Edgew	ater	, Maryland	
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	23a. Part1. Enter the disease, or complications the	t caused the deat							1 9 11	Approximate Interval Between	_
	shock, or heart failure. List only one cause on each line.										
	disease or condition resulting in death)										
	Due to (or as a consequence of):										
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ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.)  Due to (or as e consequence of):  About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1 About 1										
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Be Completed by Physicial	9 ☐ Unknown 9 ☐ Ui	nknown									_
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ü		te of Injury onth, Day, Year)	28b. Time of Injury	f 28c. Inju Wo	ry <i>a</i> t 'k?	28	8d. Describe	how injury occur	red		
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al C	29a. Certifier 1 Certifying Physician: To										_
Medical Certification: To	(Check only 2 Medical Examiner: On the										
Me	29b. Signature and title of certifier			29c. Licen	se number			29d. Date signe	ed (Month	, Day, Year)	_
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31. Date filed (Month, Day, Year)

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Registrar's Signature

Anne Arundel Medical Centr Annapolis MD ZI + 01

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Reg. No.

2. Date of Death

3. Time of Death

<b>Physicia</b>	Ì
/Medica	
Examine	

Month 06 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Somerford Place Annapolis 9. Birthplace (State or Foreign Country)
Rhode Island 8. Date of Birth (Month, Day, Year) 06/29/1931 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 12 M 2□ F 039-16-2194 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Anne Arundel Crownsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō United States 820 Northfield Lane 21032 or items 23a 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 □ No
If Yes, Give
Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ş 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Real Estate Developer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Liberata Ricci Mario DeStefano ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If item 27 is permit. Pages 1 and 5 Department of Health Important: If item 27 i any injury or other tra once. 820 Northfield Lane, Crownsville, Maryland 21032 Gina M. DeStefano/Daughter 20a. Method of Disposition
1 ⊞ Burial 2 □ Cremation 3 □ Removal from Spate 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation Cedar Hill Cemetery 06/15/2009 Suitland, Maryland 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate interval Between Onset end Death 23 . Part & Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician e MENTA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed anding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant et time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2  $\square$  No 1 ☐ Yes Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 ☐ Accident 5 Pending investigation ours after death.

ieral Director: A
filled in by the fu 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 🌿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) 29b. Signature and title of certific 29c. License number who conpleted cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY ANNAPULISMA 2140) KENTA M 445 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records,

			Ameno# 5,10E,18, State of Maryland / Depar 1- State 198 Per FH AACO HEALTH DEPT. CMH 6/16/09 Registrar Cert	rtment of F tificate of	Health and M <i>Death</i>	ental Hyg	Jiene leg. No. 2 ()	09 2093
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dear	th Day	3. Time of Death
	/Medic	al	JEAN E. DETRANCIS  4a. Facility Name (If not institution, give street and number)	4h City Town o	r Location of Death	06	4c. County of	01 1110
	Examin	er	Anne Arundel Medical Center	Annapo1			,	rundel
Ī	Funeral		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		577-46-1065	months Bayo	Tiodio IIIIII			Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ation				10d. Inside City Limits
	a-f sh	ctor	Maryland Prince George's Lanham					1 □Yes 2√√No
	or 28	Funeral Director	10e. Street and Number 6548 Princess Carden Parkway	10f. Zip Code		1	log. Citizen of Wh	nat Country?
	s 23a	eral	0346 Fillices Garden Farkway	20706		poifu You or No	U.S.A.	- American Indian,
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanther must be notified at once.	þ	1 Never Married 2 1 Married 1 Yes 2 1 No	as Decedent of P Yes, specify Cuba □Yes 2 🔀 No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)		White
2	72 hor	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki.	ent's Usual Occup	oation during most of working	ng I	16b. Kind of Bus	iness/Industry
7	vithin ane.	Ig II	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired	d) -	:		eorge County
N	filed w Hygie tther t		-12-   Adminis	strative	Assistan			epartment
a	ld be lental <b>ked c</b> ic eve	To Be	James Henry Keene, Jr.		18 Mother's Name Hannah Bel Hanna Be	le Martir <del>II Mart</del> :	l <del>In</del>	
ary	shou and N Is mar	_	19a. Informant's Name/Relationship (Type. Print)	Address (Street	and Number or Rura	I Route Numbe	r, City or Town, S	itate, Zip Code)
<u>ر</u> ر	and the search m 27 her tr		Alfred DeFrancis 6548 1	Princes	<del>Garden Pa</del>	<del>rkway</del> , ]		Md. 20706
	ages 1 nt of 1 :: If ite		20a. Method of Disposition  X⊠Burial 2 □ Cremation 3 □ Removal from State  Lakemont 1	atory or other place Memorial	ce)			City or Town, State
baitimor	artme ortani injury		4 Donation 5 Other (Specify) Gardens	Name and Addre	; 6/11,			ville, Maryla uneral Home
ñ	Dep any onc		10 Perfixing 10	6000 Ann				land 20715
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		1			Approximate Interval Between Onsel and Death
	Physician		resulting in death)	genor	n louk	our		day
	/Medical Examiner		Due to (or as a consequent of):	o .				,
	7 4	je.	Sequentially list conditions, if any, leading to hit negligible cause. Enter Underlying Cause (Disease or injury					
	ecuted and transi	Examiner	that initiated events c.					
og,	be exician (		resulting in death) Last Due to (or as a consequence of):					
00/00	ificate g phys is the	edical	d					
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M		Ectopic pregnand Other (specify) _	су		23d. Date Mon	of delivery th Day Year
Ž.	s that gned b e deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use contrit	bute to the cause of death?
cords	equire	ted t				1 □ Y	es 22 No 3	3 ☐ Probably 4 ☐ Unknown
nec	The law r cate has be page 2 sh	Completed				24a. Was a autops perfor 1 ∐Yes	med? pr	ere autopsy findings available ior to completion of cause of eath? □Yes 2 □No
VII.	certifi rector,	Be	25. Was case referred to medical examiner?  Hospital:	2□ DOA Oth	26. Place of Death			
5	Physer this eral di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injul	ry at 2		ence 6 Other	
5	ath. r: Afte	ation	1 Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	M 1 □	k? ]Yes 2□No			
DIVIS	ial or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	1	28f. Location (S City or Tow		r or Rural Route Number,
	he Hospit in 24 hour he Funera pletely fill.	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the best of examination and/or investigation and mapping stated.	occurred at the ti estigation, in my o	ime, date and place, opinion, death occurr	and due to the ded at the time, o	cause(s) and mar date and place, ar	nner as stated. nd due to the cause(s)
	Vith Com	Ň	29b. Signature and title or certifie	29c. Licens	se number	2	29d. Pate signed	(Month, Day, Year)
	whi	-	30 Name and address of person who completed cause of death (Item 23a) Gype Pr	rint)	1 214=	58	zune	01,2007
	.70	ł a	31. Date filed (Month, Day, Year)  32. Registrar's Signature	FENSE	HAHWA	7 HNA	TAPOLI)	MD2140/
	Sta Registra		JUN 12 2009 Serone S. J.	and				

09-04809 Dennis Finz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 20935

		1- For State Registrar		Cer	rtificate o	f Death				Reg. No.			
Physicia		Decedent's Name (First, Middle)	e,Last)					2	Date of De		Year		me of Death
dical Exami		Dennis Henry	Finz						June 17,	2009	rear	1	440 hrs
		4a. Facility Name (if not institution	n, give street and num	nber)		4b. City, Town,	or Location	of Death			County of D		
A		Washington County H	lospital			Hagersto	wn			l W	/ashingto	n	
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. I	ast birthday)	If Under 1 Y		_	8. Date of E	Birth(MM/D	DD/YYYY) 9	. Birthplac oreign	ce (State or
Director		214-46-5427	1XM 2_F	62	Yr		ays Hours	Min.	Jan.	21.1	947	Country)	Maryland
	Ì	Usual Residence of Decedent					1						
any		10a. State 10b. County		10c. City,	Town or Loca	tion							Inside City Limits
ld thow	_	Maryland Washi	ngton Coun	ty Had	gerstow	m						1	Yes 2X No
urylar 8a-f.s at on	당	10e. Street and Number			300000	10f. Zip Code	)			10g. Citiz	en of What	Country?	
or 2	Director	13834 Long Ri	dae Dr			21742				II C	S.A.		
eath with the Maryland items 23a or 28a-f show any ust be notified at once.		11. Marital Status		dent Ever in U	.s. 13. W	as Decedent of		gin? (Spe	cify Yes or N			merican li	ndian, Black,
eath v item ust bo	Funeral	1 Never Married 2 X M	arried Armed For	ces?	l f	Yes, specify Cul					White, et	tc.	
ter de ", or	Ī	3 Widowed 4 Div	orced or Dates:	1965-19	968 1	Yes 2 X	No specify			5	Specify: W	hite	
urs af tural	d by	15. Decedent's Education (Spe	cify only highest grade	completed)		nt's Usual Occu	pation (Give	kind of wo		16b. Ki	ind of Busine	ess/Indus	try
72 ho	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)	during r	nost of working	ife. DO NOT	use retire	d)				7
336 thin ne.	ם	12			Driver	•				Pa	rcel	Deliv	zery Compa
ed wi	Ö	17. Father's Name (First, Middle	, Last)		·		18.Mothe	r's Name (	First, Middle	, Maiden S	Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Henry Finz					Jet	tie O	hler I	3eckl	ey		
21 ould ic ev	ပ္	19a. Informant's Name/Relations			1	g Address (St							Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	- 3	Cathy Finz-wi	fe			Long R							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition	0 D16		Place of Dispo crematory or o	sition (Name of	cemetery,		Date	20c. L	ocation - Cit	y or Towr	n, State
Baltimore, permit. Pages la Department of He Important: If ite injury or other to		1 XBurial 2 Cremation 4 Donation 5 Other S		III State	-	n Mem P	ark	6-22	-2009	Hag	gersto	wn. N	4D
nit. Hartme	- 1	21. Signature of Funeral Service			22.	Name and Addr	ess of Facilit	y Dou	glas A	A. Fi	erv F	unera	al Home
Dep Dep Initial		Dunda	Nain	,	13	31 East	ern B	lvd.	North	Hage	rstow	n. M	21742
Physician		23a. Part I. Enter the disease, or	complications that ca	sed the death	. Do not enter	the mode of dyi	ng, such as	ardiac or	respiratory a	rrest, sho	ck, or heart	Ap	proximate Interval
Medical		failure. List only one cause Immediate Cause (Final disease	A 41 1	otic Cardiov	ascular Dis	sease						De	Death
Examiner		or condition resulting in death)	Due to (or as a									$\neg$	
		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):							- 0	
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	nf):							-	
uted Id ransit		events resulting in death) Last	d.										
Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	//Medical	UNPENDED	AMENDED										
760, ficate be exe g physician a	Ned	IF FEMALE:	23c. If yes, o	utcome of preg	nancy			_		23d	I. Date of del	livery	
rtifica	an/I	23b. Was decedent pregnant in to past 12 months?	he 1 Live bir	rth	2 F	etal death	3 Ectop	c pregnan	су		Month	Day	Year
Box 687 e death certification the attending as to	Physician		known	int at time of de	eath 5 C	ther (Specify)				1000			Ì
he des	hy		9 Unknow		10. 1. 0.				00 - Dia	4-1		- 4- 45	ause of death?
s, P.O.	by F	Part II. Other significant condit	ions contributing to	death but not r	esulting in the	underlying caus	se given in P	art I.			_		4 V Unknown
S, F	ed	Morbid obesity											
cords law requi has been 2 should	Completed	l								opsy	prio	r to compl	findings available etion of cause of
Reco	Ē	-							per 1 ✓ Yes	formed?	deat	th? Yes	2 No
		25. Was case referred to medica	ıl			26.Pl	ace of Death	(Check or	-		<u>-</u>		
n of Vital Records, the Physician: The law requir After this certificate has been s funeral director, page 2 should I	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2 🗸	ER/Outpatier	nt 3 DOA	Other <sub>4</sub>	Nursing	Home 5	Resider	nce 6 (	Other:	
1 of V ting Phy. After tl funeral	-	27. Manner of Death	28a. Date o	of Injury	28b. Time of	Injury 28c. I	njury at Wor	k? 2	28d. Describ	e how inju	ry occurred		
	tior		ding	Day,Year)		1	Yes 2	No					
5 4 5 5 5	lica		Id not be 28e. Place	of Injury - At h	ome, farm, stre	eet, factory, offic	e building, e	tc. 2	28f. Location	(Street ar	nd Number o	r Rural R	oute Number, City
Is aff	Certification:		rmined (Specify)						or Town	, State)			
Divi		20a Certifier	hysician: To the best	of my knowled	ige, death occi	urred at the time	, date and p	ace, and c	due to the ca	use(s) and	d manner as	stated.	
thin 2 the I	Medical		aminer:On the basis of	f examination a									use(s)
To To	Me	29b. Signature and title of certification	and manner sta er	aleu.		29c. Lice	ense number			29d. E	Date signed	(Month, E	Day, Year)
		1/1/11/1	1 h =	4		О.	C.M.E.			June	e 18, 200	9	
		30. Name and address of persor	who completed cause	e of death (Item	n 23a) *								-
SH 9+1			Assistant Medica	,		nn Street, B	altimore,	MD 212	:01				
	tate			jistrar's Signat			<u> </u>						
Regis		I IIIN T	8 2009	Lescon	A. As	arke							

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Pleas	se Type or Pri							egible.	
	-	For State Registrar		State of M	larylan		partment of F ertificate of		Mental Hy	/giene Reg. No.	009	20936
Physicia /Medica		1. Decedent's Name			is TE	1			2. Date of De Month	Day	Year	3. Time of Death
Examine		,		give street and number	)			r Location of Dea	th		ounty of Death	d o 1
Funeral		5. Social Security N		dical Ctr.	ge (In yrs.	last birthda		apolis	8. Date of Bi		nne Aru	place (State or Foreign
Director		577-28-23 Usual Residence of	338	1□M 2□ F	86	Yrs	Months Dave	Hours Min	8. Date of Bi (Month, D 9/26)	71922	Coui	'N
yland how		10a. State	10b. County		10c. Cit	y, Town or	Location				1	0d. Inside City Limits
e Ma 8a-f s	Director	MD		Arundel		Annaj	polis			_		1 □ Yes 📆 No
with the a or 2 the n		10e. Street and Nur		<b>.</b>			10f. Zip Code	/ 0.1		10g. Citize	n of What Cour	ntry?
death ms 23	Funeral	937 Mast.  11. Marital Status	line Dr	12. Was Decedent		S. 1	3. Was Decedent of H If Yes, specify Cub	401 Hispanic Origin? (	Specify Yes or No	0- 14.	USA . Race - Americ	
B 0 B	2	1 ☐ Never Marri		Armed Forces' ed 1121Yes 2  If Yes, Give Year or Dates:	No WW	III	If Yes, specify Cub. 1 □ Yes 2 ☑ No	an, Mexican, Puei Specify:	rto Rican, etc.)	i	Black, White, pecify:	etc. Mite
72 hou	Completed	(Spec	15. Decedent's	s Education t grade completed)		16a. De	cedent's Usual Occup	pation during most of we	orkina	16b. Kind	of Business/In	dustry
vithin sne. than "	ğ	Elementary/Seco		College (1-4or	5+)	life Life	e. DO NOT use retire: airman	d)		то1	anhana	Co
filed v Hygie Sther 1		17. Father's Name (	(First, Middle, L	.ast)		кера	alligii	18. Mother's Na	me (First, Middle		ephone Irname)	
Aental Aental rked c	To Be	George A	lvin Fo	ster				Nelin	a D'Arez	zzo		
2 should and Mis mail		19a. Informant's Na	ame/Relationsh	ip (Type. Print)		19b. Ma	ailing Address (Street	and Number or F	Rural Route Numb	ber, City or T	own, State, Zip	Code)
l and lealth im 27 ther tr	8	Daisy Fos		Wife	00h F		Mastline sposition (Name of	Drive A	nnapolis		21401 tion - City or To	Ptoto
permit. Pages 1 and 2 should be filed within 72 hours D.partment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, It of Medical Exagging.			☐ Cremation :	3 🗆 Removal from State		emetery, c	rematory or other place on Nationa				gton, V	
mit. Poartme	+	21. Signature of Fu	5 □Other (Sp. unexal Servet		ALI	Inge	22. Name and Addre		-			
20 5 6 9		10	J. 9	~~~ <u>`</u>			12 Ridgel	y Ave.	Annapoli	is, MD		
-				complications that cause only one cause on each	d the deat	h. Do not	enter the mode of dyin	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause ( disease or condition resulting in death)	on	a. Due to (or as	wi	UN.	Cenon	10/0	nal for	ailu	u	Weller
Examiner		0		b Due to (or as	a consequ	uence oi).	ľ	Ty per	tenn	on		glen
led sit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nations, imediate erlying	Due to (or as	s a conseq	uence of):		, ,				
executed in and ial-transit	Exan	that initiated events resulting in death) L	S	c Due to (or as	s a conseq	uence of):						
be icia			1	d								
ertifica Jing pt e as tt	Med	IF FEMALE:		00-16								
attend for us	Physician/Medical	23b. Was decedent in the past 12	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant	2 🗀 Feta	I death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Ey .		230	d. Date of delive Month	ery Day Year
the cby the tached	ly y	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9 ☐ Unknown								
es #	≥	Part II. Other signif	licant condition	ns contributing to death	but not resi	ulting in the	e underlying cause giv	ven in Part 1.	_	tobacco use		he cause of death?
e law red has bee	Completed								24a. Was	s an	24b. Were auto	opsy findings available impletion of cause of
: The cate h	통 [								perf 1 □ Yes	ormed?	death? 1 ☐ Yes	2 □ No
siclan certifi rector,	g	25. Was case reference examiner?		Hospital:			tiont SCI DOA Oth	or:	eath (Check only			
y Physer this eral di	0	1 Yes 2. 27. Manner of Deatl	th	28a. Date of Inj	ury	28b. Time	e of 28c. Inju	4 🗀 Nursing	Home 5 ☐ Res 28d. Describe			fy)
ending ath. or: Aftu	atio	1  Natural 2  Accident	5 Pending investiga	ation	ay, Year)	Injur		k?  Yes 2□No				
al or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could no determir	28e. Place of in	jury - At ho tc. <i>(Specif</i>	ome, farm,	street, factory, office			(Street and I wn, State)	Number or Run	al Route Number,
	edical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medicai E	g Physician: To the bese examiner: On the basis and manner s	of examina	wledge, de ition and/o	eath occurred at the ti r investigation, in my	me, date and place opinion, death occ	ce, and due to the	e cause(s) a , date and p	nd manner as s lace, and due to	stated. o the cause(s)
To th Vithir Comp	Me	29b. Signature and	title of certifier	0126	015	Az w	29c. Licens	e number	20	29d. Date	signed (Month,	Day, Year)
OX	Y	30. Name and addr	ress of person w	vho completed cause of	death (Iten	1 23a) (Typ	De, Print)	ISE H	16 HWI	Ay An	INAPOLI	MAZIYU
State		31. Date filed (Mon			rar's Signa	ture	/	1 1				
Registra		J	UN 12	2009 Sekon	a p	1. A	have					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12 FUNDERBURK-SMITH CHARDON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Seat Pleasant 6412 Greig St. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1 M 2 XF June 19, 1957 Washington, DC Director 579-80-3470 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Seat Pleasant MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e Items 23a o USA 20743 6412 Greig St. Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No ō 1 ☐ Yes 2 ☒ No þ Specify: "natural", o 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical dother than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Hazel Mae Funderburk Willie B. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2718 Belknap Circle
San Diego, CA. 92106 19a. Informant's Name/Relationship (Type. Print) if Health Tshombre Carter-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Alexandria, Va. Metropolitan Crematory 6-16-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 21. Sign of Fundatal Service Licens Suitland, Md. 4308 Suitland Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sive Heart Diseas 2 Immediate Cause (Final **Physician** a Arterioscherotic disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐XNo Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed death? certificate 1□ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day 5 Pending investigation

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physiclan: After Director:

Baltimore, Maryland 21215-0036

Certification: To

24 hours a

Medical within 24 29b. Signature and title of certifier SALVADON

2 Accident

3 Suicide

29a. Certifier

4 Homicide

3001

6 ☐ Could not be

determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

State Registrar

9-04834 Paniel Lee Foley		Please Type or Print in Black Indelible Ink. Fasure of Copi Amend Trems Plack Indelible Ink. Fasure of Pleast Indelibration of Health and Mental I	64 Que Tié	gible.	
anier Lee i oley		1- For State Certificate of Death		£ U	09 2093
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Dear	eg. No. th	3. Time of Death
Medical Exami		Daniel Lee Foley	Month June 18, 2	Day Year 2 <b>009</b>	2114 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea	th	4c. County of D	eath
		5128 Haines Lane Westminster		Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H  Months Days Hours M	in	1	Birthplace (State or Foreign Country)
Director		213-13-5522   1x M 2 F   26 Yrs.	Sept	26 1982	MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<b>.</b>	L	MD Carroll Westminster			1  Yes 2 <b>∑N</b> o
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What 0	Country?
with the Maryland ns 23a or 28a-f sho he notified at once		5128 Haines Lane 21158		USA	
ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( 15. Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Origin? ( 15. Never Married 2 Married Armed Forces)		- 14. Race - Al White, et	merican Indian, Black,
death or ite	Ē	1 XYes 2 No	to Ricali, etc.)		White
s after	۵	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		орсону.	
2 hour	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind or during most of working life. DO NOT use re		16b. Kind of Busine	ss/maustry
vithin 7: ene.	Completed	12 Electrician		Electr	ical
5-0036 led within 72 hours. Hygiene. other than "natur:	ទី	17. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Middle, I	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	å		Rosa Sa		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fahmastie event, the Medical Examiner must he notified at once	의	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of			
프 면 플 링 플	0.60	OO. Mathed of Disposition	estminst Date	20c. Location - City	1158
Ore ges 1 st of H i. If it	Ш	1 🔀 Burial 2 Cremation 3 Removal from State crematory or other place) 5/2	3/2009		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	П	4 Donation 5 Other Specify: LakeView Mentorial Garde 21. Size to of Fungral Service Licensee 22. Name and Address of Facility		Sykesvi	
Ba Ba Perm Depa Injur	Ц	Pritts Funeral Ho	me and C	hapel, P.	A. MD 21157
Physician		23 Part I. Lawr the thease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arm	est, shock, or heart	Approximate Interval
√Medical ≟xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Intraoral Shotgun Wound			Between Onset and Death
Zxammer		or condition resulting in death)  Due to (or as a consequence of):			
	ا ۾	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	틝	cause. Enter Underlying Cause (Disease or injury that initiated			
red nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
e executed sian and rial - t ansit	ica	d. UNPENDED AMENDED			-
760, icate e physici the buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	verv
687 ertifica ding p	au/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month	Day Year
Box 68760, e death certificate e the attending physicide of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as the bunder of for use as	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown			
that the de ted by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
ires that the signed by	흵		1 Yes	s 2 🗸 No 3 🗌	Probably 4 Unknown
w requir	활		24a, Was autop		autopsy findings available to completion of cause of
eco he law ite has	Completed		perfo	rmed? deat	
tal Recition: The certificate	ပ္	25. Was case referred to medical 26.Place of Death (Checi		2 1	100 2 10
Division of Vital Records, lal or Attending Physician: The law requir rs after death.  In Director: After this certificate has been seled in by the funeral director, page 2 should the fineral director.		examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nurs	ing Home 5	Residence 6 🗸 C	ther: Scene
ing Pt After After funeral	Ë	27. Manner of Death 28a. Date of Injury 1 □ Natural 5 □ Pending POUND: 28b. Time of Injury 28c. Injury at Work? FOUND: 1 □ Yes 2 ✔ No.	28d. Describe I Subject sho	how injury occurred	
SiOn ttend death. ctor:	ä	2 Accident Investigation Jun 18, 2009 2057 hrs			
Divis pital or At ours after of neral Direc filled in by	ertification:	3 ✓ Suicide 6 Could not be determined (Specify) Single Family	or lown, S	state) -	Rural Boute Aluraber, City
ospita hours unera ly fille	ပျ	29a. Certifier		ane, Westminster	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To wit	¥∣	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
		Carol Hallan O.C.M.E.		June 19, 2009	)
_ ,	ŀ	30. Name and address of person who completed cause of death (Item 23a)		L	
	[	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
Sta Registi		31. Date filed (Month, Day, Year)  32. Begistrar's Signature			
1,60 (8)		ULIN ALL VIEW   / MARKA CI. LEWIS			

			_ roi	artment of Health and Mer tificate of Death	ntal Hygiene Reg. No	
			Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death
П	Physici /Medic		Richard Lee Glessner			7 2009 7:12 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death
Н			Coffman Nursing Home	Hagerstown	Wa	shington County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		213-12-7631 - 91		oril 21,1	918 Maryland
	and w	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	laryli sho	5				1 ☐ Yes 2 X No
	28a-	Director	Maryland Washington County Williams	10f. Zip Code	10g. Ci	tizen of What Country?
	with Se or		15235 Clear Spring Rd.	21795		U.S.A.
	ns 20	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica		14. Race - American Indian,
(O	r Iter	Ψ	Armed Forces? I		an, etc.)	Black, White, etc.
ဗ္ဗ	el', o	þ	Amed Forces?  1 Never Married 2 Married 1 X Yes 2 No 11 Yes 3 No 11 Yes 3 No 11 Yes 3 No 11 Yes 3 No 11 Yes 3 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 12 No 1	1 ☐ Yes 2 💢 No Specify:		Specify: White
20	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23e or 28e-f show ent, the Madical Examinational Lectualities at	Completed	15. Decedent's Education 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentian 16a, Decedentia	dent's Usual Occupation kind of work done during most of working	16b. F	Kind of Business/Industry
2	ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	led w lygier har th			Assembler  18. Mother's Name (Fi		craft Mfg.
Maryland 21215-0036	be fi	Be	17. Father's Name ( <i>First, Middle, Last)</i> Snively Earl Glessner	·		
3	1 Mer narke	7		Cora Bell		
<u>a</u>	12 st h and 7 ts n treun					
e,	1 and Healt em 2 ther			Fairchild Ave. Have sition (Name of natory or other place)	rstown,	Ocation - City or Town, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examinat must be rediffied at an once.		1Y Rurial 2 Cremation 3 Removal from State cemetery, crem	natory or other place)		
量	artme ortani injury		`4 □ Donation 5 □ Other (Specify)	m Mem Park 6-19-20 2. Name and Address of Facility Doug	12c A F	erstown, Maryland
Ba	Depire any once	0	Dung Attin 13	331 Eastern BLvd. No	orth Hage	retown MD 21742
Ċ.			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line			Approximate
	4-343	8	Immediate Cause (Final			Interval Between
	Pnysician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	-		, spine)
Г	Examiner					1.0
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of): cause. Enter Underlying			
	nd nd transi	Examlner	that initiated events c.			
ő,	ate ba exacuted physician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
8760,		dlcal	d			
9 ×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of delivery
Вох	atteniation for us	lan	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown	JOHNS (Specify)		
<u>α</u>	res that the death igned by the atter be detached for u	by Physiclan/Me	Part II. Other significant conditions contributing to death but not resulting in the u	nderlyipg causa given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	uires n sign	q p	Clione any Desease. Hype	Teusion.	1 ☐ Yes 2	Probably 4 Unknown
00	w require been signature should b	lete	Moule Domentie		24a. Was an	24b. Were autopsy findings available
	he la e has age 2	Completed	y words		autopsy performed?	prior to completion of cause of death?
Vital	an: T	Be C	25. Was case referred to medical	26. Place of Death (C	1 Yes 2 N	0 10185 20190
	ysici s cer direc	To B	examiner?  1  Yes 2  Hospital: 1 Inpatient 2 ER/Outpatier	Other		6 ☐Other (Specify)
0	g Ph ter th		27. Manner Teath 28a. Date of Injury (Month, Day Year) Injury Injury	f 28c. Injury at 28d Work?	. Describe how inju	ury occurred
Division of	ttendin death. stor: Af / the fur	atlc	2 Accident investigation	M 1 Yes 2 No		
<u>\S</u>	l or Atter de Diracte	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f.	Location (Street a City or Town, State	and Number or Rural Route Number, te)
	ital o					
	Hosp 14 hou Fune Fely fi	ical	29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, deatl (Check only 2 ☐ Medical Examiner: On the basis of examination and/or in			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
)	2 1 K 1		Amilel Charles	036655	Tu	Ve 18' IMAC
			30. Name and address of person who completed cause of death (Item 23a) (Type.		0,5%	
וע	45+1		324 East ANTIGAM STALL.	fuile 200. Hogen	Honer, 1	00 71740 ON
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi	ar	JUN 18 2009 / 1	and a		

			For State Registrar	State of Marylan	-		nt of He te of D			Reg. No	7111	09	2094(	
Г	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Gertrude	Alice		Gil:	lum		2. Date of De Month June 1.	ath 2 <b>,</b> 2	y 009	Year	3. Time of Death 5:00 P M	
	Examin	_	4a. Facility Name (If not institution, give 12517 Lisa Drive			4b. City		ocation of Death		4c.	County o	of Death 11ega	any	
	Funeral Director		Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. S	·	ast birthday) Yrs.	If Unde Months	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 07/07/	ıy, Year)		9. Birthp Coun	lace (State or Foreign try) yland	n
	f show	or	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc		- 1 1					10	0d. Inside City Limits	
	n with the h	al Director	MD   Alleg 10e. Street and Number 12517 Lisa Dri	<u> </u>	Cl		cland p Code	21502		10g. Cit	tizen of W		iry?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Widten Event, and its notified at	by Funeral	11. Marital Status  1 □ Never Married 2 【X Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1				panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-		κ, White, ε	an Indian, etc.	
21215-0036	filed within 72 hou Hygiene. other than "natur:	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	kind of w OO NOT	ual Occupat ork done du use retired) cretar	ring most of work	ing		ind of Bus	siness/Inc		
pu	2 should be filed within n and Mental Hygiene. Is marked other than 's raumatic event, the means and the means and the means are should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should be should	Be	17. Father's Name (First, Middle, Last)	Election	D = 1010			18. Mother's Name	e (First, Middle		Surname	e)	rmire	
Maryland	should nd Mer marke imatic	ဥ	Newton  19a. Informant's Name/Relationship (Ty	Elwood pe. Print)	Berr		s (Street ar	Verna nd Number or Rur	al Route Numb	er, City				_
	1 and 2 Health a em 27 is		Norman E. Gillum	·				ive, NE,					502 wn, State	_
mor	Pages 1 lent of H nt: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State 1	lace of Disposemetery, crem			ry 06/15	/2009		nber]			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other <u>once.</u>		21. Signature of Funeral Service Licens		22	. Name a	and Address	•	ams Fan	nily	Fune	eral	Home, P.A 21502	•
	Physician /Medical Examiner	ner	23a. Part T. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	re		Faillur		irrest,		/	Approximate Interval Between Onset and Death	<u>S</u>
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):									_
.O. Box 6	the death certif y the attending iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3 □	Ectopic Other (	pregnancy specify)				23d. Date Mor		ery Day Year	
rds, P.	quires that en signed b uld be deta	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the ur	iderlying	cause giver	n in Part I.					ne cause of death? pably 4 🗌 Unknow	n
of Vital Records,	: The law recate has becate has becate has becate has because 2 should be set to be set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set	Completed							24a. Was auto perfo 1 🗆 Yes	psy ormed?	p	Vere auto prior to co leath? Yes	psy findings available mpletion of cause of 2  No	е
Vita	rsician s certifi lirector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	FB/Outpatien	t 3 🗆 [	Othor	26. Place of Deat			6 □ Othe	er (Specif		_
ion of	nding Phy ith. :: After this e funeral c	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury Work?		28d. Describe				<u>"                                    </u>	
Division	ital or Atterns after dearal Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, stre	eet, facto	ry, office		28f. Location ( City or To			er or Rura	al Route Number,	
	te Hosp 1 24 hou le Funei bletely fil	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.										
	To withi	M	29b. Signature and title of certifier		W	2	9c. License D002				ate signed une		Day, Year) 2009	
	7185		30. Name and address of person who co				ve C	umberlar	nd MD	215	02			
	Sta	_	31. Date filed (North Par Year)	32. Registrar's Signa			_ v = 0	winder Tar	, 1111		<u> </u>			_

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0,2009 Allen Dale Hazelton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Year) Min. 1 X M 2 □ F Months Days Hours 20, 1957 Director 51 108-60-8387 Sep. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Directo Bowie Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8622 Myrtle Avenue 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify ğ Specify: 3 Widowed 4 Divorced White "natural" Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 Howard Hazelton Margaret Gentry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori A. Hazelton/ Wife 8622 Myrtle Avenue Bowie, MD 20715 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or o once. 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2009 Waldorf, MD Huntt Crematory

**Physician** /Medical Examiner

> Completed by Physician/Medical Examiner burial-trai Be မ

21. Signature of Funeral Service L	ensee	22. Name and Address of Facility Rober	rt E. Eva	ns Funer	cal Home
pro-1-F	fuck	16000 Annapolis Road	Bowie, M	D 20715	
shock, or heart failure. List o Immediate Cause (Final disease or condition	omplications that caused the death. Do not not only one cause on each line.	et enter the mode of dving, such as cardiac or i	respiratory arrest,		Approximate Interval Between Onset and Death
resulting in death)  Sequentially list conditions, if any, leading to immediate	b. System (of as a consequence of)				
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pulling Due to (or as a consequence of)	onsc		(1)	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	Blivery Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacco	o use contribute t	o the cause of death?
Mnen	ya.		1 ☐ Yes	2 <b>X</b> No 3□ F	Probably 4 Unknow
Mena	tic encep	halopathy	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a d be detached for cate has l page 2 s certificate nours after death.

neral Director: After this
filled in by the funeral di within 24 hours a To the Funeral I

	,			/			,			performed? 1 □ Yes 2 No	death? 1 ☐ Yes	2 □ No	
25. Was case refer	red to medical						26.	Place of Dea	th (C	Check only one)			
examiner? 1 ☐ Yes 2 🔀	No	Hospital	1 Inpatient 2	☐ ER/Outpatient	3 🔲 [	AOC	Other: 4	☐ Nursing H	lome	5 ☐ Residence 6	☐Other (Specify	)	
27. Manner of Deat 1 Natural 2 ☐ Accident	5 Pending investigation	1	. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes	2 🗆 No	280	d. Describe how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	. Place of Injury - At building, etc. <i>(Spec</i>	home, farm, stree	t, facto	ory, of	ffice		28f.	Location (Street and City or Town, State)	Number or Rural	Route Number,	
29a. Certifier	î⊠ Certifying Ph	yslcian:	To the best of my kr	nowledge, death	occurre	ed at	the time, o	date and place	e, and	d due to the cause(s)	and manner as st	ated.	_

25.

27

Certification:

Medical

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

8 GOOD LUCK ROND

1X Yes 2 □ No

20 104

			Please 1					nk. Ensure			-	
			For State Registrar	State of Ma	aryiand			of Health and of Death	wentai ny	Reg. N	0000	20942
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last</i> Mary Elizal		or	Но	ooks		2. Date of Do		009 Year	3. Time of Death 10:45 P M
-	Examin		4a. Facility Name (If not institution, give Bowie Health Center	street and number)			4b. City, Tov Bow	wn, or Location of Deat	h	4	oc. County of Dea Prince Geo	orge's
	Funeral Director		287-22-9801	7. Age	e (In yrs. las 83	st birthday) Yrs.	If Under 1 \ Months D	ear If Under 24 Hrs eays Hours Min.		rth Pay, Yea , 192	9. Bi	rthplace (State or Foreign ountry) O
	aryland show	<u>-</u>	Usual Residence of Decedent  10a. State 10b. County			Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	he M	ectc	Maryland Prince Geo	rge's	Temp	ole H	IIIS 10f. Zip Co	.de		100 /	Citizen of What C	
	with 1	i Di	3502 29th Avenue				2074				USA	ountry:
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:				t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or Noto Rican, etc.)		14. Race - Am Black, Whi	
2-0	72 hou natura lical E	eted	15. Decedent's Edu (Specify only highest grad	cation	1	16a. Dece	dent's Usual C	Occupation Hone during most of wo	rkina	16b.	Kind of Business	/Industry
21215-0036	d within giene.	Comple	Elementary/Secondary (0-12)	College (1-4or 5	+)	`life. l	it Execu	retired)	rking	Se	ars & Roe	ebuck
Maryland	be file ntal Hy ed othe event,	To Be (	17. Father's Name (First, Middle, Last)	То	1			18. Mother's Na	me (First, Middle	e, Maid	en Surname)	Malana
ryla	hould nd Mer marke matic	유	Samuel  19a. Informant's Name/Relationship (Ty	Tay	Tor	19h Mailir	na Address /S	Leona treet and Number or R	ural Route Numi	her Cit	v or Town State	Malone Zin Code)
Ma	nd 2 s alth ar 27 Is ir trau		Bennie B. Hooks, S	•	and			ve., Temple				2/2 0000/
Baltimore,	Pages 1 a nent of He: int: If item iry or othe		20a. Method of Disposition 1 🛎 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Pla cen Ar1	ce of Dispo netery, cren ingto:	sition (Name matory or othe n Natic	nalCem. 6/	Date 25/2009		Location - City of	
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licens	ch		- 1		Address of Facility G n Hill Road O			s Funeral yland 2	Hame P.A. 0745
	Physician /Medical Examiner		23a. Pall Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lir Ovarian Due to (or as	canc	er	er the mode o	f dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin,	Due to (or as	a conseque	nce of):						
,09	e be executed sician and surial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
O. Box 6876	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	ieath 3	Ectopic preg				23d. Date of do Month	elivery Day Year
ds, P.	uires that n signed b Id be deta		Part II. Other significant conditions con Colitis , Hperkale	-		ing in the ui	nderlying caus	se given in Part I.				to the cause of death?  Probably 4  Unknown
I Records,	<b>hysician:</b> The law requires tha his certificate has been signed I director, page 2 should be det	Completed by							24a. Wa: auto peri 1	opsy formed	?   death?	autopsy findings available completion of cause of
Vital	clan: ertific ector,	Be (	25. Was case referred to medical examiner?						ath (Check only	one)		
of	Physician: this certific al director, p		1 ☐ Yes 2 ☑ No  27. Manner of Death	lospital: 1 ☐ Inpatie 28a. Date of Inju		R/Outpatier	nt 3 DOA		Home 5 ☐ Res		6 ☐ Other (Sp	ecify)
Division	Attending Ph ir death. ector: After th by the funeral	ation	1 Natural 5 ☐ Pending investigation	(Month, Day	y, Year)	Injury	м 200.	Injury at Work? 1 ☐ Yes 2 ☐ No	Zod. Describe	7 (104)	ijury occurred	
Divis	2 = E	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	c. (Specify)				City or To	ówn, St	ate)	Rural Route Number,
1	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	29a. Certifier (Check only one)	sician: To the best per: On the basis of and manner sta	f examination	ledge, deatl on and/or in	h occurred at vestigation, in	the time, date and place my opinion, death occ	e, and due to th urred at the time	e cause e, date	e(s) and manner and place, and du	as stated. le to the cause(s)
A	To the within 2 To the comple	Me	29b. Signature and title of certifier	100				icense number			Date signed ( <i>Mor</i>	nth, Day, Year)
			1 / 1 / 1 / 1 / 1	XUA			1	JJJ1		U/	TO/ 7009	

State Registrar

10

31. Date filed (Month, Day, Year)

Dr. Ikechi Okwara, M.D., 6201 Greenbelt Rd. Suite U-15, College Park,MD 20740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

# Please Type or Brint in Black Indelible Ink. Ensure All Cories Are Legible. State of Paryland / Department of Health and Menta Tygiene

2009 20943

		I-For State Registrar		Certifica	ate of I	Death			Reg. No.						
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle, Nathaniel W. I						2. Date of De Month June 13,	Day Yea	3. Time of Death ar 1815 hrs					
		4a. Facility Name (if not institution, Prince Georges Hospita				. City, Town, or L Cheverly	ocation of Dea	ith	4c. County Prince C	of Death George's					
Funeral Director			Sex 7. Age (  X M 2 F 54	In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M		3/1955	y) 9. Birthplace (State or Foreign					
ie Maryland or 28a-f show any lied at once.		Usual Residence of Decedent  10a. State D.C.  10b. County  10c. Street and Number	10	oc. City, Town Was	hing	ton			10g. Citizen of Wi	10d. Inside City Limits 1 X Yes 2 No					
ith the Maryland 23a or 28a-f sho notified at once.		811 Barnaby	St.,S.E. # 3	303		10f. Zip Code <b>200</b>	32		U.S.A.						
r death wi or items must be	by Funeral		ded if Yes, Give Year or Dates:	₹ No	If Yes	Decedent of Hisp s, specify Cuban, res 2 X No	Mexican, Puer specify:	to Rican, etc.)	White Specify:	e - American Indian, Black, te, etc. Black					
21215-0036 uld be filed within 72 hours after Mental Hygiene, marked other than "natural", cevent, the Medical Examiner	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)  12th	College (1-4 or 5+)	, ,		S Usual Occupation of working life. In the color of working life. In the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of the color of t			16b. Kind of Bu	usiness/Industry  None					
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medics	S B B	17. Father's Name (First, Middle, L. Roosevelt I.				18	_		, Maiden Surname						
MD 2121; tid 2 should be fil tith and Mental F m 27 is marked aumatic event, 1	٥	19a. Informant's Name/Relationship Katherine E. Bro								wn, State, Zip Code)					
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and I important: If item 27 is reinjury or other traumatic		20a. Method of Disposition  1 XXBurial 2 Cremation  4 Donation 5 Other Spei	3 Removal from State	cremat	ory or othe	on (Name of cemer place)  n. Park		Date 5/22/09		- City or Town, State					
Balf permit Depart Impor injury		21. Signature of Funeral Service Li	1. Sall		1492	Burrou	gns Ave	≘.,N.E.,	wasningt	Sons Co., Inc. Vashington, D.C. 20019					
Physician /Medical xaminer		23a. Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease	each line. a. Sharp Force Injur	ies	ot enter the	mode of dying, s	uch as cardiad	or respiratory a	rrest, shock, or he	eart Approximate Interval Between Onset and Death					
	اير	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):													
	틝	cause. Enter Underlying Cause (Disease or injury mat immated events resulting in death) Last	Due to (or as a consequ												
execul an and al - tra		UNPENDED	dAMENDED												
68 certif	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1 Live birth 4 Pregnant at tin	2	Feta	I death 3	Ectopic preg	nancy	23d. Date o Month	of delivery Day Year					
P.O. Box as that the death c gned by the attente detached for us		1 Yes 2 No 9 Unknot	9 Unknown	ut not resulting	g in the un	derlying cause gi	ven in Part I.	23e. Did	tobacco use cont	tribute to the cause of death?					
	ompleted by							24a. Wa	san 24b.	Probably 4 Unknown  Were autopsy findings available prior to completion of cause of					
of Vital Records, ig Physician: The law requir ther this certificate has been s ineral director, page 2 should be	<b>∵</b>		<del></del> -			_		1 <b>✓</b> Yes	formed?	death? 1 ✓ Yes 2 No					
ital	m	25. Was case referred to medical examiner?	Hospital:	2 V ER/O	utnotiont		of Death (Chec	sing Home 5	Residence 6	Other:					
n of Vi	<u>.</u>	1 ✓ Yes 2 No 27. Manner of Death	1 Impatient		Time of Inj		at Work?		e how injury occur						
ਵਾੜੀ ੂ ₹ ਵੀ	ertification:	1 Natural 5 Pendin 2 Accident Investig	ation		3 hrs	1 Ye	es 2 🗸 No	Subject st	abbed and cu	ıt					
Divi	' ) F	3 Suicide 6 Could r 4 Homicide			arm, street,	ractory, office bu	iliding, etc.			ber or Rural Route Number, City					
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	edica	one) 2 Medical Exami	sician: To the best of my k ner:On the basis of examin and manner stated.			n, in my opinion,	death occurre		te and place, and	due to the cause(s)					
	2	29b. Signature and title of certifier	26/1	K.		29c. License O.C.N			June 14, 2	ned (Month, Day, Year) 2009					
en		30. Name and address of person w Zabiullah Ali, M.D. As	no completed cause of dea		11 Penn	Street, Baltir	more, MD 2	21201							
	State 31. Date filed (Month, Fry 2009 32. Registrar's Signature A. Asaki														

			For State Registrar	State of M	arylan			of Heal		lental Hygid	ene g. No. 200	9 20944
	9		1. Decedent's Name (First, Middle,	Last)						2. Date of Death Month	Day Ye	3. Time of Death
-	Physicia /Medic		DORIS	MA	ARIE	H	IOLLA	ND		June	9°, 20°	09 4:47 P M
7	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, 1	Town, or Loca	ition of Death		4c. County of I	
		ш	Upper Chesape	ake Medic	cal C	enter	•		Air		H	arford
H	Funeral Director		5. Social Security Number 220–22–0849	6. Sex 7. A 1 M 2 F	lge (In yrs. I	last birthday) Yrs.	If Under Months		ours Min.	8. Date of Birth (Month, Day, 1	9. 927	Birthplace (State or Foreign Country)  Maryland
	P.		Usual Residence of Decedent  10a. State 10b. County		100 Cib	v. Town or Lo	antina					10d. Inside City Limits
	anyla ehov	_	,	0 7	100. 010	y, TOWITOI LO	Cation	CI +				1 ☐ Yes 2 X No
	Ba-f	ecto	MD. Har	ford			10f. Zip		reet	10	g. Citizen of Wha	at Country?
	with t	급		70 3			101. 2.10		7.57	1.0		ed States
	s 23	erai	441 Glasgow	KOAQ 12. Was Deceden	at Ever in II	S 13 V	Was Deced		ic Origin? (Sp	acify Yes or No-		American Indian,
	Item Ingr	Funeral Director	1 Never Married 2 Marrie	Armed Forces	s?		f Yes, spec	ify Cuban, Me	exican, Puerto	ecify Yes or No- Rican, etc.)		White, etc.
38	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	No Sp	ecity:		Specify:	Black
21215-0036	filed within 72 hours after death with the Maryland Hygiens. Hygiens than "natural", or Items 23s or 28s-( show sther than "natural", or Items 23s or 28s-( show ent, the Madical Examinat must be notified at	Completed	15. Decedent's	Education		16a. Deced	dent's Usua	l Occupation	most of work		6b. Kind of Busin	ness/Industry
2	hin 7 9. Ned Wed	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT us	e retired)		n'ig		
7	or th	Son	7	0			Но	usewi				Home
ng	d oth	Be	17. Father's Name (First, Middle, L		(77.7					First, Middle, M		D7
Maryland	Men Men arke	ဥ	George	Edward	Th	nomas			Maude		abeth	Beasley
<u>Jar</u>	2 sh and ie m	1	19a. Informant's Name/Relationshi			Total Control				al Route Number,		
ď.	fealth fealth om 27 ther t		Milton Hollar  20a. Method of Disposition	nd (Husba		441 (		and the second second			Oc. Location - Cit	and 21154
ğ	or of		1 ABurial 2 Cremation	3 □Removal from Stat	e c	emetery, crer	natory or of	her place)				
Baltimore,	it. Pertant		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Sen Ce L.		Chlest			d Address of				Maryland
Ba	permit. Peges 1 end 2 should be ilied within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Say Inportent: If item 27 is marked other than "natural, or items 23a or 28a-6 show say injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Furieral Service L	diam H	Pi				ه بید			n Funeral
			23a. Part1. Enter the disease, or o	complications that caus	ed the deat			P.A.				Maryland Approximate
	Physician /Medical Examiner	her	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Squentially list conditions if any, leading to immediate	a. Due to (or a	POX	uence of):	Asc	pirat	ion			Interval Between Onset and Death
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):						
P.O. Box	at the death certific by the ettending pi tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	I death 3	Ectopic pro				23d. Date of Month	
	luires that n signed b	þ	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying c	ause given in	Part I.			ute to the cause of death?
Il Records,	Physician: The law requir this certificete has been si ral director, page 2 should	Completed								24a. Was an autopsy perform	ned prid	ere autopsy findings available or to completion of cause of ath?
ij	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	1.000	,			Place of Deat	h (Check only one	9)	
o	Phys this aldir	J.	1 ☐ Yes 2 No 27. Man/er of Death	1 ☐ Inpa		ER/Outpatier 28b. Time o			☐ Nursing Ho	ome 5 Resider		
n	ding ! After funer	io io	1 ☑Natural 5 ☐ Pending	(Month, L	Day Year)	Injury	M	8c. Injury at Work? 1 ☐ Yes	2 🗆 No	200. 0030100 110	w injury occurred	
Division of Vital	To the Hospital or Attending f within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investig. 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place of	Injury - At he	ome, farm, sti			2 (110	28f. Location (Str City or Town		or Rural Route Number,
Ö	Ital or A											
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1 ✓ Certifying (Check only 2 ☐ Medical E	Physician: To the be- examiner: On the basis and manner	of examina	owledge, deat tion and/or in	h occurred ivestigation	at the time, d , in my opinio	ate and place, n, death occur	and due to the ca red at the time, da	luse(s) and mannate and place, and	ner as stated. d due to the cause(s)
	within 2 To the comple	Mec	29b. Signature and title of certifier	4			290	License nur	mber	29	d. Date signed (	(Month, Day, Year)
	- s - ō		1/1/	504	h.	mi	> 1	)005	722	3	Tuno =	Month, Day, Year) 26,2009 MD 21014
			30, Name and address of person v	who completed cause o	of death (Item	n 23a) (Type,	Print)				VIII O	Town,
-	5		Fermin Barr	austo M	1.0.1	500 U	poor	Ches	apeak	e Dr. E	Bel Air.	MD21014
	Sta Registi		31. Date filed (Month, Day, Year) JUN 3 0 200	9 Severy	strar's jigna	park	9		0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <sup>□</sup>2009 **Physician** 5:48 PM M Gilda Fern Hoffman June 23, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death Examiner Frederick 6130 Edmont Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. Year 1932 Months 1 □ M 2 💢 F 77 10, Mary Land 217-28-0967 Usual Residence of Decedent be filed within removed that Hygiene, and Hygiene, sed other than "natural", or items 23a or 28a-f show ted other than "natural by notified at the Wediewl Evan Inc. out by notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick 1 ☐ Yes 2 No Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21704 6130 Edmont Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status □Yes 2X No Yes, Give 1 Never Married 2 Married 1 □ Yes 2√2 No Specify. Specify: White 3X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Menchey William Mackley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Wallingford Court, Jefferson, MD 21755 Mrs. Therese A. Oakley, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery June 27, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Fundal Service Ligans 22. Name and Address of Facility
Keeney and Basford PA Funeral M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): corraino mon Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ZHO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

the

certificate

this

To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

death.

Baltimore, Maryland 21215-0036

12 should be filed w h and Menta! Hygie 7 Is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev

**Funeral** 

**Director** 

attending physician a for use as the burials been signed by t should be detach Completed has e 2 s page director, Be Certification: To After th funeral

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

perform 2 No 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

and manner stated.

28b. Time of Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

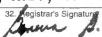
29d. Date signed (Month, Day, Year) June 24, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sebastien Kairouz, M.D., 46 B Thomas Johnson Drive, Frederick, MD 21702

State Registrar 31. Date filed (Month, Day, Year) JUN 30

6 ☐ Could not be



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DIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Robert William Johnson 17 2009 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 111 Harvard Road Hagerstown 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 82 202-16-9895 08/12/1926 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or? 21742 US 111 Harvard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 C1 ☐ 3 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced 1945 Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louie (nmn) Johnson Be Katie (nan) Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 Harvard Road, Hagerstown, ND 21742 Patricia E. Johnson / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, MD Cedar Lawn Mem Park 6/24/09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>^</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has 1□ 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 1 🗌 Yes 1 Inpatient Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Attending Natural 5 ☐ Pending 1 □ Yes 2 □ No death. investigation after death.

Director: A 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10x

State Registrar

JUN 19 31. Date filed (Month Degistrar's Signature

29b. Signature and title of certifier

30. Name and address of

on who completed cause of death (Item 23a) (Type, Print)

NC

29c. License number

29d. Date signed (Month, Day, Year)

Moun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29d pr dr., g892,06/30/09 bbath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 09 09 **Physician** 20 20 06 1350 Victor Elmer Layton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner WMHS Braddock Campus Allegany Cumberland If Under 1 Year | If Under 24 Hrs. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ountry) MD 1 ☑ M 2 ☐ F Months Days Hours Min. Feb 26, 213-24-6828 Director 80 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Exeminer must be notified at WV Mineral Wiley Ford 1 ☐ Yes 2 ☑ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Rt. 1 Box 123 26767 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Tyes 2 No Specify þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance Hills Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer James Layton Jessie M. (Deneen) Layton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P+ 1 Rov 123 Wilev Ford WV 26767 19a. Informant's Name/Relationship (Type. Print) Mary Ellen Layton wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page:
Department of
Important: If
any Injury or
once. = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 6/24/2009 MD Cumberland 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility at Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Paint: Ent. I the disclassic, or o miclicatic his that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart fail (in.) List only one crust on each line.

Immediate Cause (Find disease or condition resulting in dumn)

a.

Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine (W) the attending physician and hed for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) detached ☐Yes 2☐No 9 I Inknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ATRAL FIB RILLATION 1 □ Yes 2<sup>1</sup> Ho 3 Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 ⊟No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 □ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ↑ Aftural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or A 24 hours after 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 06/21/2009 29b. Signature and title of certifier 29c. License number NOMBR DOO 64167

State

State 31. Date filed (Month, Day, Year)

JUN 3 0-2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

BERLAND MY

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			For State	e of Maryland	•	rtment of H t <i>ificate of L</i>			0.0	0.0	2001.0
			Registrar  1. Decedent's Name (First, Middle, Last)		Ceri	inicate of L	Jealli	2. Date of Dea	Reg. No.	119	3. Time of Death
Г	Physicia	an	ROSE LEONETTI					Month	Day 200	Year	4:15 p <sup>M</sup>
Ų.	/Medic	V	4a. Facility Name (II not institution, give street an	d number)	- 1	4b. City, Town, or	Location of Death	DOME		ty of Death	4.13 P
ļi.	Examin	er	645 Knights Island Rd		t 1	Earlevi.	lle		Ceci	il .	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n /. Year)	9. Birthp	place (State or Foreign
b.	Director		189–18–1079 <sup>1□ M</sup> 🛣	86	Yrs.	World Days	Tiodio Isini.	May 6			nsylvania
	w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Fown or Loc	ation				1.	10d. Inside City Limits
	Maryla f sho ed at	ō	MD Cecil	Far	levil	10					1 ☐ Yes 2 XNo
	the 28a-	rect	10e. Street and Number	Lat	TEATT	10f. Zip Code			10g. Citizen of	f What Cou	ntry?
	3a or st be	E D	645 Knights Island Rd	Glen 8 Lo	t 1	21919			U.S.A	4.	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 XNo s, Give		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Spe un, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Ra Bli Spec	ace - Americack, White,	
Maryland 21215-0036	2 hours atural" cal Exa	ted by	15. Decedent's Education		16a. Deced	ent's Usual Occup	ation	1	16b. Kind of	Business/Ir	ndustry
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2	filed v Hygie ther t nt, th	ပ္ပ	17. Father's Name (First, Middle, Last)		11011	Charce	18. Mother's Name	(First, Middle,			
aŭ	ld be ental ked o	To Be	Ercole Gianfrancesco				Maria S	iano			
ary	shou ind M s mar	-	19a. Informant's Name/Relationship (Type. Print	)	19b. Mailin	g Address (Street	and Number or Rura	ıl Route Numbe	er, City or Tow	n, State, Zi	p Code)
Ž	and 2 salth a 127 is		Anna Maria Buehler (d			Box 306		wn, MD.			
ore	es 1 and He of He of He of other		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 ▼Removal	irom State I		sition (Name of natory or other plac		ate	20c. Location	,	
Ĕ	Pag tment tant:		4 □ Donation 5 □ Other (Specify)	St.		r & Paul		29/09	Spring	Jfielo	d, PA.
Baltimore,	permit Depar Impor any In		21. Sign wife of uneral Service Lious service	M00510	2	238 S. B	ss of Facility angemi Fur road St.	Philad	elphia,	, PA.	19145
١			23a. Part: Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. on each line.	Do not ente	er the mode of dyin	ng, such as cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	Ιİ	Immediate Cause (Final disease or condition resulting in death)			brillation	on				
4	/Medical Examiner		Du	ie to (or as a conseque	nce of): entia						
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	uted	Examiner	Cause (Disease or injury that initiated events								
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<u>~</u>	10 0	Con						perfo 1  Yes	ormed? 2√2 No	death? 1 ☐ Yes	2 🗆 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:			Oth	26. Place of Death				
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Division or Vital Records,	Atter	ifica	- El Could not be	Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (	Street and Nui wn. State)	mber or Ru	ral Route Number,
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	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: On and								
	To th Withir To th comp	Me	29b. Signature and title of certific			29c. Licens			29d. Date sig	•	
			<b>b 5</b> 7	^	ND	D006	2190 		June	24, 2	2009
			30. Name and address of person who complete								
			Shahnawaz Khan, M.D. 31. Date filed (Month, Day, Year)	111 W. 32. Registrar's Signatu	High :	St. Suite	e 105 Elk	ton, M	2192	1	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 3 0 2009	Marca .	1 1	barked					
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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 **Physician** 200 Russell Clarence MILLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 141 High Street Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 66 Maryland 7, 1942 Director 218-40-4000 Nov. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show iral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 USA 141 High Street items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after of artment of Health and Mental Hygiene.
ortant: If Item 27 is marked other than "natural", or iten Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) shoe manufacturer unknown unknown laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Edward Miller Sr. Margaret Louise Frazier ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 141 High Street, Hagerstown, Maryland 21740 Linda Moats - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 TBurial 2 ☐ Cremation 3 Removal from State permit. Page Department important: If any injury or Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem.Park 6/23/2009 2. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician colon Ad cho carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bunial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Donknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To funerai 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

Medical Compus Road 1/110

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0026579

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:50 A M June 18, 2009 Sandra Lee McDonald /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 47 Wakefield Road Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year)
ec. 27,1944 Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🗓 F **Director** Washington D.C. 229-66-2436 64 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits show 10b. County 10c. City. Town or Location rai", or items 23a or 28a-f shov Extrairur must be notified at Director 1 XYes 2 ☐ No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 Wakefield Road 21740 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Maryland 21215-0036 1 ☐Yes 2 No Specify. Completed by Specify: 3 X Widowed 4 Divorced White "natural" other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Production Basket Company 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F Willie Dickie Patricia Kidd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If item 27 is 60 115 Ware Place Winchester, Virginia Robert W. Conrad (Son) item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any Injury or
once. = 5 Enders & Shirley Crematory 6-20-09 Berryville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A. 425 South Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-small months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leaf of the first of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) the death certificate be executed and physician a the burial-Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2. No detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 🗆 No 1 ☐ Yes 2 2 No 1 ☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2.■No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of at or Attending P s after death. I Director: After t After 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide To the Hospital within 24 hours a to the Funeral I completely filled 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 18, 2005 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 11110 Medical Compar Rd Ste 130 Hagerston Scott A. Wegner MD Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 19 2009

			For	State of M	arylan						lental Hy	giene	)		
			1 - State Registrar			Cei	rtifica	te of L	Death			Reg. No	2000	201	951
	Physici		1. Decedent's Name (First, Middle, La. Evangeline	st)	Jo		Мс	Greev	V		2. Date of Dea Month June	Da	y Year 2009	3. Time of 0	
4.	/Medio		4a. Facility Name (If not institution, giv	e street and number)	}	-		y, Town, or	<u> </u>	of Death	oune		County of Dea		5
			14609 Baltimor	re Pike, N	ΙE		Cu	mberl	and				Allega	ny	
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			Usual Residence of Decedent				L				05/02/	1925		or Arren	LIIIa
	arylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo		, ,						10d. Inside City	
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	23a or	Funeral Director	14609 Baltimor	e Pike, N	E		101. 2	ip Code	21	502		rog. Cit	US	*	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			f Yes, sp	edent of H ecify Cuba 2∏No	ispanic Or In, Mexica Specify	n, Puerto	ecify Yes <i>o</i> r No- Rican, etc.)		14. Race - Ame Black, White Specify:		
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DHMH 17 Rev 1/2001

			For State		State	of Mary				ealth and N	/lental Hy	giene	2000	20050
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_	Funeral		5. Social Security Number	6. Se	ex	7. Age (In	yrs. last birthda	) If Under	1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th Voor	-	pplace (State or Foreign intry)
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UNISION	r Atter	Certification:		Could not be determined	20e. Flac	e of Injury -	At home, farm, s	street, factory	, office		28f. Location (	Street an wn. State	nd Number or Ru	ral Route Number,
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	To the Hospital or Attending Privithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral privity.	Medical	29a. Certifier 1 0 (Check only one) 2	Certifying Ph Medical Exan	niner: On the	ne best of m basis of exa nner stated.	amination and/or	ath occurred investigation	at the tir , in my o	ne, date and place pinion, death occu	red at the time	cause(s date and	) and manner as d place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of	certifier	17			290		e number			te signed (Month	
	3		18/Mu	P	De	5			D09	157		J	June 12,	2009
	ms		30. Name and address of						ad C	treet, Cu	mhenler	nd M	ID 2150	2
	Sta	te	31. Date filed (Month, Day		now, M	Registrar's	Signature		u s	oreet, Cl	mnei.Täl	ia, r	∪راے س	
	Registr	ar	JUN I D	2009	Clever	1.	park							

18. Mother's Name (First, Middle, Maiden Surname)

20c. Location - City or Town, State

Anna Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Grey Fox Ct., Middletown, MD 21769

Smithsburg Crematory 6/13/2009Smithsburg, MD

r 28a-f show notified at with the giene.
If than "natural", or items 23a or the Medical Examiner must be r death v permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

ģ

Completed

Be

MD

17. Father's Name (First, Middle, Last)

Albert Pascoe

20a. Method of Disposition 1 Burial 2000 remation

4.☐Fonation

19a. Informant's Name/Relationship (Type. Print)

3 □Removal from State

John Miller (Son)

**Funeral** 

Director

**Physician** /Medical **Examiner** 

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra physician the attending pl signed by t this After t within 24 hours after death.

To the Funeral Director filled in by

Division or Vital Records, P.O. Box 68760,

10 KB

2

Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes Completed 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 M Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Medical 29a. Certifier 29b. Signatur Ltitle of certifier 00062223 add ss of person who completed cause of death (Item 23a) (Type, Print) RAVEEN BILARUM, 70 196 TJ DRIVE, FREDERICK, MD - 21702

1. Date filed (Month, Day, Year)

32. Registrar's Signature

5 ☐ Other (Specify) 21. Surre 105 seral Servi Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or shock, or heart failure. List Imme ause (Final disease or condition resulting in death) MONTHS 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2**X** No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

20b. Place of Disposition (Name of cemetery, crematory or other place)

State

Registrar

31. Date filed (Month, Day, Year)

JUN 16 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Пач Year Physician 1103AM 2000 Murphy, Jr. 16 George R. JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** EASTON TAIbot he Memorial HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. 73 July 9 1935 Director 146-26-9817 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 1 ¥Yes 2 ☐ No Funeral Director DE Sussex Millsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or USA 35591 Sussex Lane 19966 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after I Hygiene. 1 Never Married 2 X Married Maryland 21215-0036 white 1 ☐ Yes 2 XNo Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16b. Kind of Business/Industry or other traumatic event, the Madical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Local Union Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be f h and Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lnjury or other traumatic evone. Mary Magee George R. Murphy, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 35591 Sussex Lane, Millsboro, DE 19966 Marie T. Murphy Baltimore. 20b. Place of Disposition (Name of New St. Mary Screenses). Cemetery. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 22, 2009 Bellmawr, New Jersey 21. Signature of Fund 22. Name and Address of Facility Wilm, DE 19803 I Service Licensee Chandler Funeral Home 2506 Concord Pike 23a. Part / Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner E140501 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ Nephrectomy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' ueatn/ 1 ☐ Yes 2 ☐ No N/A certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29b. Signature and title of cert 29d Date signed (Month, Day, Year) June 16 200 16 2009

Registrar

State

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31. Date filed (Month, Day,

32. Registrar's Signature

**Funeral** 

Director

ural", or items 23a or 28a-f show LExaminer must be notified at

2121	d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		Self-empl	use retire oyed	(d)	
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/ar	uld be Jenta rked ric ev	TO B	Carl Theodore Ro	ose				Robbie	Mont
ary	shou and N s ma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing Addre	ss (Street	and Number or F	lural Route l
Σ	and 2 salth a r 27 i		William G. Michae	e1/Husband		2509 King	gsway	Rd. Ft.	Wash
ore	of He of He fiter		20a. Method of Disposition		20b. P	lace of Disposition (A emetery, crematory o	ame of rother pla	ce)	Date
Ĕ	Page nent ant: II ury o		1 ☐ Burial 2 🗖 Cremation 3 4 ☐ Donation 🖊 5 ☐ Other (Spe	cify)		as Cremato		6/1	5/2009
Baltimore, Maryland 212	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'le Mone.		21. Signature of Funeral Socyice Lic	also				ess of FacilityGe Hill Rd.	_
			23a. Part 1. Enter the disease or co shock, or heart failure. List or	omplications hat caused the	ne death	. Do not enter the m	ode of dyi	ng, such as cardia	ac or respira
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Во	atten for us	ian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐ Fetal	death 3 Ectopic			
Ö	he de	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime or a	eath 5□Other	(specify) _		
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	Part II. Other significant conditions	s contributing to death but	not resu	ılting in the underlying	cause gi	ven in Part I.	23e.
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Ο̈́	after after Dire d in b	Certification: To	4 ☐ Homicide	building, etc.	(Specify	)	,		City
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A :	to the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Ex	taminer: On the basis of e and manner state	examina ed.	tion and/or investigati	on, in my	opinion, death occ	curred at the
HA	vithii To th	Me	29b. Signature and title of certifier	0		2	9c. Licen	se number	
			1 Day	2.00			H	66666	5
	2		()	- 1 V					
	6		30. Name and address of person wh	no completed cause of dea	th (Item	23a) (Type, Print) -	11-	Ch. m. 2	1

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 13. 2009 **Physician** 4:00P Rita R. Michael /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2509 Kingsway Rd. Prince George Ft. Washington If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 8/30/1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2ÅF 78 Months Days Hours 408-54-2343 Alabama Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Prince George Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA 2509 Kingsway Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced eted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Yarn Crafters Middle, Maiden Surname) gomery Number, City or Town, State, Zip Code) ington,MD. 20744 20c. Location - City or Town, State Edgewater, Maryland P. Kalas Funeral Home Hill, Md. 20745 Approximate Interval Between Onset and Death tory arrest, 23d. Date of delivery Day Month Year Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed Yes 2 1 No 1 ☐Yes 2 ☐No orly one) Residence 6 Other (Specify) cribe how injury occurred ation (Street and Number or Rural Route Number, or Town, State) to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) JUN 1 7 2009 Sever A. Harris Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner WARD GENERAL HOWAR COLUMB If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F Piperger, WV 211-30-2539 68 Director 09/15/1940 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director WV Hardy Moorefield 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 181 C-Town Road 26836 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced 'natural", White 16b. Kind of Business/Industry other traumatic event, if a Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event. Its Surveyor/ Operator Factory 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) See Town Road Moorefield, WV 26836
ition (Name of Date 20c. Location - City or Town, State Eugene Whipps -MPOA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WVU Human Gift Registry Morgantown, WV 22. Name and Address of Facility WVU Human Gift Regsitry 21. Signature of Funeral Service Licensee PO Box 9131 Morgantown, WV 26506 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical asn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Dunknown ģ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 □Yes P□No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Ne 1 ☐ Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUMURU

2009

DHMH 17 Rev 1/2001

within 7

DO064539

HOWARD COUNTY GENERAL HOSPITAL,

29d. Date signed (Month, Day, Year)

CO LUMBIA

09-04932

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Veronica McKenney 2009 20957 1- For State Certificate of Death Rea. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1230 hrs **Medical Examiner** June 22, 2009 Veronica McKinney 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8715 First Avenue #615 D Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** oreign North Country Carolina Months Davs Hours Director August 22,1946 577-64-2869 2X F 1 M Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show MT Silver Spring Montgomery permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importaot. If item 27 is anxed other than "oatural", or items 23a or 28a-f sho iojury or other reaumatic eveot, the Medical Examiner muss he notified at ooce. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8715 1st Ave. #615D 20910 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married Yes 2 X No Black. Specify: 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: ₹ S 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Legal Secretary Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Unknown Be Mary McKinney 19b. Mailing Address (Street and N **Caribon** 4028 <del>Caribou</del> St. 19a. Informant's Name/Relationship (Type, Print ) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Stanard-Nelson/Sister 4028 Bowie., MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Landover, Maryland 07/03/09 Donation 5 Other Specify. Harmony Memorial Park Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Lansee 22. Name and Address of Facility 716 Kennedy St. NW, Washington, DC Approximate Interval s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical T9b, per Fh G893 ////09 TT 23a,PII,27, & #1 as noted, X UNPENDED AMENDED physician the burial per ME g894 8/26/09 Hospital or Atteodiog Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed 24b. Were autopsy findings available certificate has been 24a. Was an prior to completion of cause of autonsv performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene DOA 1 Yes ER/Outpatient 3 After this မ funeral 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: e Hosping.

n 24 hours after death.

he Fuoeral Director: A 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 [ Could not be Suicide or Town, State) (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME June 23, 2009 ul. 30. Name and address of person who completed codes of death (Item 23a) TR Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day ) State Registra

9-04667 Philip Martin Pos	st, II	Please Type or Print in Black Indelil State of Maryland / Departme			ole.
	- 1	1- For State Certifica	te of Death	Reg. N	<u>. 2009 2095</u>
Physicia Medical Exami	ın/ ner	1. Decedent's Name (First, Middle,Last) Philip Martin Post II		2. Date of Death Month Da June 12, 200	9 00431115
`,		4a. Facility Name (if not institution, give street and number) Eastern Blvd. and Antietem Street	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 212-04-3210 28	day) If Under 1 Year If Under 24Hrs  Months Days Hours Min		MM/DD/YYYY) 9. Birthplace (State or Foreign County)  1980 County)
with the Maryland ms 23a or 28a-f show any be ne tiffed at once.	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of MD Washington H.  10e. Street and Number 532 Lynnehaven Dr. Apt. 34	agerstown  10f. Zip Code  21742	10g. (	10d. Inside City Limits 1 X Yes 2 No  Citizen of What Country?  USA
fter death I", or iter	by Funeral		13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of vuring most of working life. DO NOT use reti	Rican, etc.)  work done 16	14. Race - American Indian, Black, White, etc.  Specify: White  b. Kind of Business/Industry
15-0036 Tled within 72 hours a Hygiene. d other than "natura" the Medical Examin	Completed		accountant	(First, Middle, Maid	aviation
그 모은 물 3	Be	Philip Martin Post	Paula	Byrnes	
MD and 2 sho alth and 2 sic m 27 is raumati			Mailing Address (Street and Number or 4208 Garnet Dr.,		cown, MD 21769  Oc. Location - City or Town, State
Baltimore, N permit. Pages I and Department of Healt Important: If item injury or other trau		1 X Burda 2 Cremation 3 Removal from State cremato	ry or other place)	17/2009	Middletown, MD
Physician /Medical xaminer	ner	2/ g. Part I. Inter the disease, or complications that caused the death. Do no failure. List only one cause on each line.  Immuliate dause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	I POB 18. Middle	town. MI	21769
ecuted and - transit	al Examiner	Collegacy or injury that initiated events resulting in death) Last d			
1760, ficate be exe g physician a	Medica	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box 68760, to death certificate be the attending physic red for use as the bur	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No 9 Unknown  1 Live birth 4 Pregnant at time of death 5			Month Day Year
S, P.O. uires that the n signed by id be detach	۾	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	1 Yes	cco use contribute to the cause of death?  2 •• No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed	25. Was case referred to medical	26.Place of Death (Check	24a. Was an autopsy performe 1 Yes 2	
Vita ysician	To Be	examiner?	Othor		sidence 6 🗸 Other: Scene
ision of Vi Attending Physis redeath. rector: After this by the funeral dir	ation: T	1 Natural 5 Pending Jun 12, 2009 0635	Time of Injury 28c. Injury at Work?  hrs 1 Yes 2 ✓ No	28d. Describe hov Driver in collis	
Division spital or Atten ours after deart littled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by t	Certification:		rm, street, factory, office building, etc.	or Town, State	eet and Number or Rural Route Number, City e) nd Antietem Street, Hagerstown, MD
To the Hospital within 24 hours To the Funeral	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.			
F 3 F 8	Me	29b. Signature and title of certifier  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Authorities  Autho	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 12, 2009
10		39. Name and address of person who completed cause of death (Item 23a)			

KB

Laron Locke MD.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year)

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 11,2009 9:45P Johanna E. Pettersen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel <u> Heritage Harbour Health & Rehab</u> Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 212-34-6134 85 Director June 17,1923 Norway Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Wodical Examiner must be notified at Director 1 ¥Yes 2 ☐ No Maryland |Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1000 Boucher Avenue 21403 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify \$ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lars Ebne Bertha Braatvedt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda E. Schultz / Daughter</u> 1002 Boucher Avenue, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Crematorv 6/13/09 Baltimore, Maryland 21/Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home. 147 Duke of Gloucester St., Annapolís, MD 21401 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** الم ي الح Prozomowin /Medical Due to (or as a consequence of) Examiner ARDIONTOPATUS Sequentially list conditions, only leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation of thours after death.

Funeral Director: Af the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the further of the fu 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39637 6-12-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGEAS MITCHECE 5 2001 MEDICAL PARKDAY, ANNACOLIS MO 21461

State Registrar

JUN 15 2009

31. Date filed (Month, Day, Year)

32. Aegistrar's Signature

			For State Registrar	State of Maryl		artment of F rtificate of I		R	leg. No. 2	009	20960
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Charles Mervin F	omraning				2. Date of Dea Month June 1	Dav	009 Year	3. Time of Death 3:20 A M
-	Examin Funeral		4a. Facility Name (If not institution, give single Genesis Eldercare  5. Social Security Number 6. Sex 15	Severna Pa	rk yrs. last birthday) Yrs.	Severna If Under 1 Year Months Days	Park If Under 24 Hrs. Hours Min.	8. Date of Birth (Month., Day 5/17/	Anı	ne Arun 9. Birthp Cour	lace (State or Foreign
	Director		Usual Residence of Decedent  10a. State 10b. County		City, Town or Lo	cation		3/1//			0d. Inside City Limits
	Maryla f shov ied at	ō	MD Anne Art			polis					1 □Yes 2 🖾 No
	n the l	Director	10e. Street and Number	under	711110	10f. Zip Code			10g. Citizer	n of What Cour	•
	ath wit 23a c ust be		514 Ridge Road R	oute 11			214				USA
036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modieut Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever i Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 <b>X</b> No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		Race - Americ Black, White, pecify:	
altimore, Maryland 21215-0036	within 72 ho ene. than "natur is Medicit	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work d) —			of Business/In	
0	filed v Hygie Sther i	ပိ	17. Father's Name (First, Middle, Last)				Foreman 18. Mother's Nam				bnone
<u>lan</u>	Jental Jental rked o	To Be	Mervin Rav Pomran	ing			Ethel	Stephens	3		
lary	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic event, Ite Ma		19a. Informant's Name/Relationship (Typ	e. Print)		•	and Number or Ru		-		Code)
e, e	1 and Health em 27 ther to		Charles Pomranin		b. Place of Dispo	sition (Name of	RT 11, An	napolis.		21401 tion - City or To	own, State
mor	Pages nent of int; If it		1 Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crei	natory or other plac	<sup>∞) ¦</sup> 1 Gardens	6/16/09	9 Anna	apolis,	MD
Balti	permit. Pages Department of Important; If it any injury or o		21. Signature of Funeral Service License	_ #	1.5	2. Name and Addre	of Gloucs				1 Home. Inc
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Englished to the cause on each line.  Figure on the cause on each line.  Due to (or as a cor	ia sequence of):	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 1 Week
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Lisease or nijury that initiated events resulting in death) Last	Due to (or as a cor	sequence of):						
.O. Box	at the death certi by the attending tached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	су		23	d. Date of delive Month	very Day Year
rds, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions con Alzheimer's, D		resulting in the u	nderlying cause giv	en in Part I.				the cause of death? bably 4 ☐ Unknown
<u> </u>	The ate h	Completed						1 □ Yes	rmed? 2 <b>X X</b> No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 □ No
	lysicial lis certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	ospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth	26. Place of Dea	th <i>(Check only o</i> ome 5 ☐ Resid		Other (Spec	ifv)
Division of	ng Ph fter th ineral	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Yea	28b. Time o	f 28c. Inju Wor		28d. Describe h			
Divis	ital or Attendi rs after death. al Director: A led in by the fu	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Tou	vn, State)		al Route Number,
	To the Hospital or within 24 hours af To the Funeral DI completely filled in	Medical		ician: To the best of my ner: On the basis of exa and manner stated.							
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and marrier stated.		29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
			> /h / Shew	< nu		D20	36		6/	14/2009	)
	1 1417		30. Name and address of person who co	·							
U	10H &	te.	Gary Sprouse M.D. 31. Date filed (Month, Day, Year)	2108 Didc 32. Degistrar's S	nato Dri	ve, Ches	ter, MD 2	21619			
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DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** Valerie J.R. Patterson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 evye's Hospita Prince ve/ 6 eupes rince If Under 1 Year 9. Birthplace (State or Foreign Country) Wash. DC If Under 24 birs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 11-15-50 **Funeral** 1 M 2 F Months Days Hours 58 577-68-1759 Director Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Modical Examiner must be notified at Director MD P.G. Hyattsville 1XYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5133- 70th Place 20784 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2€No Specify. Specify: Black 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Magnose. Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Alex. Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie E. Richardson Eula M. Wright ပ 19a. Informant's Name/Relationship (Type. Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony V. Richardson, Wash. DC 20018 1815 Kearney St. N.E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 6/19/09 Suitland, Md. 4 Donation 5 Dother (Specify) uneral Service Licensee 22. Name and Address of Facility Hackett's Funeral Chapel, Inc. Nac 20011 814- Upshur St., N.W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 theros dero Tic Cardio VAS an **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate performed 2 1No 1 □ Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred \* Natural 5 Pending Injury 2 Accident investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

n 24 hours after death.

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State

Registrar

Medical

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29a. Certifier

(Check only one)

29b. Signature and title of certifier

RUA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0738 4c. County of Death Arthur Art Rowland /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Min. Days Hours 19,1950 Maryland 58 Nov. 216-54-8232 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan in a must be motified at 10a. State 1 □Yes 2 XNo Director Maryland | Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21795 15522 Falling Waters Road Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Automobile Manufacturer Tow Motor Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Elizabeth Stevens John Wilson Rowland ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15522 Falling Waters Rd. Williamsport, Maryland 21795 Becky Rowland (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park June 19,2009 Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup> Osborne Funeral Home P.A. 425 S. Conococheague St. 21. Signature of Funeral Service Williamsport, Maryland 21795 Approximate Interval Between Onset and Death 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical or as a consequence of) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗆 No certificate 1∐Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury After t (Month, Day, Year) Natural 5 Pending investigation n 24 hours after death.

ie Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 hou To the Fune completely if 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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u Z I Z I 3-0000 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.	Funeral Director	<ol> <li>Marital Status</li> <li>Never Mar</li> </ol>	ried 2 Married	Armed Forces	?	l	Was Decedent of H		erto Rican, etc.)		Black, White	e, etc.
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<u>2</u>	ficate r, pag		05.144							1 □ Yes	2		2 □ No
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or Att	within 24 hours after death.  To the Funeral Director Aft completely filled in by the fur	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not l determined	√   28e. Place of II.	njury - At ho etc. <i>(Specif</i> j		reet, factory, office		28f. Location City or To			ural Route Number,
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Please Type or Print in Black Indelibled 11k8 F15415 All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Sparhawk Frances Agnes 11 2009 9:56 A June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) Feb. 15, 1916 Maryland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** Days Hours 1 M 2 XF 93 212-09-0764 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show ir than "natural", or items 23a or 28a-f show Anne Arundel Annapolis 1 ☐ Yes 2 X No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 800 Bestgate Road Completed by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 ☑ No White Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Librarian Anne Arundel County 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If item 27 is marked oth any injury or other traumatic event Otila Elizabeth August Greenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John C. Sparhawk, Jr. / Son 764 Ballast Way Annapolis, MD 21401 Baltimore, 20b. Place of Disposition (Name of Atlantic Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date June 12, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 2009 LLC \_22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service License P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not personally one cause on each line. Her the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Aspiration Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ned by the atter 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown rate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an perform certificate 2 PNo 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending al or Attendir s after death. I Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 1/-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month State Registrar

	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Death June	1° 200	3. Time of Death 02:00P M
	/Medic	al	Mary Elizabeth Steward  4a. Facility Name (If not institution, give street and number)	4h City Town o	r Location of Death	Julie	4c. County of D	
	Examin	er	Forest Haven Nursing Home	Catonsv	ille		Baltimo	ore
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		216-24-8155			08/21/1	927   Ma	aryland
	yland how		10a. State 10b. County 10c. City, Town or					10d. Inside City Limits
	e Mar	Director	Maryland Anne Arundel Annap					1. Yes 2 No
	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show matic event, the Modical Examiner must be multifud at		10e. Street and Number 218 Sumner Road	10f. Zip Code	.401		og. Citizen of What United S	
	ns 23	Funeral		3. Was Decedent of H		pecify Yes or No-		merican Indian,
9	after or itel		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Mo	1 Yes, specify Cub	an, Mexican, Puerto  Specify:	Hican, etc.)	Black, W Specify:	
Maryland 21215-0036	hours tural",	ed by	3 LXWidowed 4 □ Divorced Year or Dates:	cedent's Usual Occup	nation		6b. Kind of Busine	
215	in 72 s. In "nat	Completed	(Specify only highest grade completed) (G	ive kind of work done  o. DO NOT use retire	during most of work	ing		
212	filed with Hygiene ther the tht, the	Com	12 Op	erator				ephone Compan
		Be	17. Father's Name (First, Middle, Last) Thomas E. Suitt		18. Mother's Nam Anna Co	e (First, Middle, M o11ins	laiden Surname)	
ž	should be and Mental marked o	ဥ		ailing Address (Street			City or Town, Star	re, Zip Code)
S S	alth ar 27 is 27 is		1/D 1	Sumner Roa				
altimore,	es 1 a of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, of	sposition (Name of crematory or other pla	ce)		20c. Location - City	
Ē	t. Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Kalas C	rematory	1		_	, Maryland
Baj	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic es once.		21. Signature of Angles Soffice Licensee	22. Name and Address 2973 Solor	ess of Facility (Ge)	orge P. K nd Rd. Ed	kalas fun Igewater.	eral Home MD 21037
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.					Approximate Interval Between
est,	Physician		Immediate Cause (Final disease or condition	le le				Onset and Death
	/Medical Examiner		resulting in death)	1. 0	1 . 1	1	1:	
	Lxummer	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	retic Co	ndivios	scopi c	71580R	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c					
Ö,	e exection and and and and and and and and and an		resulting in death) Last Due to (or as a consequence of):					
Box 68760,	icate be executed physician and s the burial-transit	an/Medical	d					
SX 6	leath certific attending p for use as i	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of	delivery
Ö.	death ne atte	sicia	in the past 12 months?  1 □ Yes 2 ▼ No  1 □ Hoknown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		Month	Day Year
<u>Р</u>	at the de d by the etached	Physici	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in th	a underlying cause di	ven in Part I	23e Did tob	pacco use contribut	te to the cause of death?
ds,	w requires that s been signed b should be deta	þ	Demon 16	e underlying cause gr	voir art art i.			Probably 4 Unknown
S	w requ	lete				24a. Was ar	24b. Wer	e autopsy findings available
Re	The law ite has	Completed				autopsy perform	ned? deat	to completion of cause of h? Yes 2 \sumbox No
Ita I	sician: The L certificate he irector, page?	BeC	25. Was case referred to medical examiner?			th (Check only one		
0	Physi this c	၉	1 ☐ Yes 2 🗖 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outps  27. Manner of Death   28a. Date of Injury   28b. Tim	ttlent 3 L DOA	A		ence 6 Other (	Specify)
Division of Vital Records,	ding Physin. Th. After this of funeral dire	Certification:	1 Mainter 1 5 □ Pending (Month, Day, Year) Inju 2 □ Accident investigation	ry Wo	ork? □Yes 2□No	26u. Describe 110	w injury occurred	
VISI	Atten er deat ector: by the	ifica	3 ☐ Suicide 4 ☐ Homicide	street, factory, office		28f. Location (Sti	reet and Number o	r Rural Route Number,
ā	ital or irs afte ral Dir led in	Cert						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my knowledge, or the best of my k					
	To the within To the Somple	Mec	29b. Signature and title of certifier	29c. Licen	ise number	2:	9d. Date signed (A	fonth, Day, Year)
	- 00	D	Doctor Malocen Mb	D	1550	3 1	June	122009
•	a Carr		30. Name and address of person who completed cause of death (Item 23a) (Ty AMATUN UNATEM 50	Dolphi	nst,	Baltin	nore MI	122009
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 15 2009  32. Registrar's Signature	V				
			TOIL - O DOUG ( PRINCE) OF					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

09-04964	ļ.
Harry W.	Shivery

rry W. Shiver		I- For State	ate of Maryla	and / Depar	rtment of tificate of	Health ar Death	nd Mei	ntal Hyg		eg. No.	21	009	2096
Physicia		Registrar  1. Decedent's Name (First, Midd						1	Date of Dea Month	Day	Year	3. Time of De 1721 hr	
ıl Exami			arry Will:		ery, Sr	b. City, Town, o	r Location		June 23, 2		County of Dea		
		4a. Facility Name (if not institution Union Hospital	on, give street and n	umber)	'	Elkton	Location	Tol Boda.		С	ecil		
		Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye	ar If Un	der 24Hrs.	8. Date of Bi	rth (MM/I	DD/YYYY) 9. E	irthplace (State	or
Funeral Director			1XM 2F	78	Yrs	Months Da	iys Hou	ırs Min.	SEPT	15.	1930 Fore	Country)Mary	land
		215-28-0940 Usual Residence of Decedent	I A M Z	10					ODI I	10,	1,00		
any		10a. State 10b. County		10c. City,	Town or Locat	on						10d. Inside	
nd show ice.	<u> </u>	Maryland Ced	cil	E	lkton_						4117		ZANO
Maryland 28a-f show any d at once.	Director	10e. Street and Number				10f. Zip Code			1	10g. Citi:	zen of What Co	ountry?	1
vith the Maryland s 23a or 28a-f show e notified at once.	ä	294 Appleton	Road			2192	1				nited S	tates erican Indian, E	Nack
h with ms 2.7 be no	era	11. Marital Status  1 Never Married 2 X		ecedent Ever in U. Forces?	.S. 13. Wa	as Decedent of h es, specify Cub	Hispanic C an, Mexic	origin? (Spe an, Puerto F	ecity resion in Rican, etc.)	0-	White, etc		, addition
r deatl or ite	Funeral		1 X Yes	2 No		Yes 2 X	No speci	ifv:			Specify: W	hite	
s after rral", niner	þ	3 Widowed 4 Di 15. Decedent's Education (Sp	vorced If Yes, Give Your Dates:		16a Deceder	nt's Usual Occur	oation (Giv	ve kind of w	ork done	16b. l	Kind of Busines		
2 hour	ted	Elementary/Secondary (0-12		(1-4 or 5+)	during m	nost of working li	ife. DO N	OT use retire	ed)		Electri	cal Mot	or
36 thin 7 than than	Completed	12			Supe	rvisor					Manufac	turing	
5-0( ed wi tygier other	្ង	17. Father's Name (First, Middle	e, Last)						(First, Middle				
21215-0036 21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	å	Ralph Thomas	Shivery		10h Moilin	g Address (St	Ma Ment and M	artha	Cecila	L Cai	rter City or Town, Si	ate, Zip Code)	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannell Hygiera I may remain 1 filem 21 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relation				Appleto:					21921_		i
, MD and 2 sho calth and em 27 is		Loris Lee Shi	very/wire	20b.	Place of Dispo	sition (Name of	cemetery,	.	Date	20c.	Location - City	or Town, State	
Ore ges 1: t of H : If it		1 X Burial 2 Cremation				ther place) e Conce	ptio	n   June 200	e 26,		Cherry	Hi11.	MD I
Baltimore, permit Pages I at Department of He Important: If ite injury or other tr		4 Donation 5 Other 21. Signature of Funeral Service	Specify:	Ce	metery	Name and Addr	ess of Fa					11444	12
Bal permi Depa Impo injur			0 1	( , 4 .	110	3 W S+	ockt	on Sti	reet.	H.I.K.T.	on. My	21921	
hysician		23a. Part I. Enter the disease, failure. List only one caus	or complications that	t caused the death	n. Do not enter	the mode of dyi	ng, such a	as cardiac o	r respiratory a	arrest, sh	lock, or heart	Between	nate Interval Onset and
edical		Immediate Cause (Final disease	Athoropol	lerotic Cardio	vascular Di	sease							Death
ےxamineı	1	or condition resulting in death)		s a consequence	of):								
	l to	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence	of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c										
ed ed nsit	Exa	events resulting in death) Las	t Due to (or a	s a consequence	or):								
be executed ician and urial - transit	dical		AMENDE	D					_				
50, te be e nysicia	led			es, outcome of pre	gnancy				_	2	3d. Date of de	-	
Records, P.O. Box 68760 The law requires that the death certificate becare has been signed by the attending physisneap 5 chould be detached for use as the but	Physician/Me	23b. Was decedent pregnant in past 12 months?	the 1 Liv	e birth	2 !	etal death	3 Ec	topic pregna	ancy	- 1	Month	Day	Year
OX 6 ath ce	Sici	1 Yes 2 No 9 U	Int marrie	egnant at time of o	5 (	Other (Specify)				1			
the de	A	Part II. Other significant con	-		resulting in the	e underlying cau	ise given	in Part I.				te to the cause	
s, P.O. irres that the signed by the detached	<u>غ</u>	?							1	Yes 2		Probably 4	
Division of Vital Records, has on Attending Physician: The law requirers after death.  In precent: After this certificate has been sind in bure to see the fine former of the control of the fine former of the fine former of the fine former of the fine former of the fine former of the fine former of the fine fine former of the fine fine former of the fine fine fine fine fine fine fine fin	Completed								24a. W	as an utopsy	pric	re autopsy findi or to completion	ngs available of cause of
Recor The law ricate has I	a L								1 ✓ Ye	erformed es 2		eth?  Yes	2 No
	C   100		ical			26.F		eath (Check	only one)				
Vital F hysician: this certifi		examiner?	Hospital: 1	Inpatient 2	✓ ER/Outpatie		Othe		ng Home 5			Other:	
of \officers	্   ⊢	27 Manner of Death	28a. D	ate of Injury lonth, Day,Year)	28b. Time o		. Injury at	-	28d. Descr	ibe how	injury occurred	l	
ion tendii eath.	<u>.</u>	1 ✓ Natural 5 P 2 Accident Ir	ending evestigation				Yes		00/ 1	(Ct-o	t and Number	or Rural Route	Number City
Division of prints or Attending Phous after death.	Cortification:	3 Suicide 6 C	ould not be 28e. F	Place of Injury - At	t home, farm, si	reet, factory, off	fice buildir	ng, etc.		n, State		Of Rulai Route	realization, and
pi ou pi	ا الق	4 Homicide  29a. Certifier 1 Continue	etermined (Spec			auread at the tim	no date a	nd place ar	d due to the	cause(s)	and manner a	s stated.	
= 2 E €	completely	(Check only 1 Certifying one) 2 Medical E	Physician: To the Examiner: On the ba	best of my knowless of examination	edge, death oc n and/or investi	gation, in my op	inion, dea	ath occurred	at the time,	tate and	place, and due	e to the cause(s	)
To the within To the	Loo Zon	29b. Signature and title of cer	and mann	er stated.			icense nu		-			(Month, Day,	
	*	CAU & C	ila of	1		0	C.M.E			J	une 24, 20	09	
_		30. Name and address of per	son who completed	cause of death (It	em 23a)								
			Assistant Medi			n Street, Ba	Itimore	, MD 212	01				
	Staf	e 31. Date filed (Month, Day Ye	0 2000 32	2. Registrar's Sign	nature /	barker	)						

OCME

		1	For State Registrar	Flease			d / Depa	artment of H			giene Reg. No.	2009	2096
	Physicia	n		e (First, Middle, Last)			Smi			2. Date of Dea	Day 19	2 os7	3. Time of Death
	/Medic Examine	er '	•	f not institution, give	spital			Baltimore		8. Date of Birt		unty of Death	lace (State or Foreign
	Funeral Director		5. Social Security N 217-42-  Usual Residence of	0453	x 7. Ag	e (In yrs. la	S Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	y, Year)	3 Mar	
	-f show		10a. State	10b. County  Charles			Town or Lo						0d. Inside City Limits 1XXes 2 □ No
7	with the a or 28s	Direc	10e. Street and Nu		ot.			10f. Zip-Code 2064	6		_	of What Coun	
36	s 1 and 2 should be filed within 72 hours after death with free maryland if Health and Mental Hygiene. If Health and Mental Hygiene. To smarked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	₫∤	11. Marital Status	dge Stre	12. Was Decedent Armed Forces? 1 ☐ Yes 2. If Yes, Give Year or Dates:		3. 13.	Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 X X o	-	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14.	Race - Americ Black, White, e	an Indian, etc.
21215-0036	n "natural",	Completed by		15. Decedent's Ed cify only highest grad	ucation	5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor		16b. Kind	of Business/In	dustry
nd 212	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any injury or other traumatic event, the Media once.	Be Com	17. Father's Name	(First, Middle, Last)			Exec	utive A	18. Mother's Na	me (First, Middle	, Maiden Su		OV T.
Maryland	should be nd Menta marked matic ev	<u>P</u>		Wilfred		<u> </u>	19b. Mail	ing Address (Street	1	ie Ann ural Route Numb			Code)
e, Ma	1 and 2 s Health ar em 27 Is ther trau		20a. Method of Dis	L. Smith		20b. P	Place of Disc	Lodge S		Date		aryland tion - City or To	
Baltimore,	t. Pages tment of tant: If it ijury or o		1 <b>∑</b> Maurial 2 4 ☐ Donation	Cremation 3 5 Other (Specify uneral Service Licens	)		inity	matory or other place.  Mem.Gr 22. Name and Address	dns. 26				Maryland
Ba	permit Depar Impor any ir once.		Lori	1 Best	- Jels	M00	641 5	635 Was	hington	Ave.,	La Pl		
	Physician /Medical		23a. Part 1. Enter shock, or hea Immediate Cause disease or conditi- resulting in death)	on	a. Due to (or as	4 /	Vp5	perfusi					Interval Between Onset and Death
	Examiner ansit	Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease of that initiated even	onditions, mmediate lerlying r injury ts	b. Due to (or as								,
	e be executed /sician and ne burial-transit	ical	resulting in death)	Last	Due to (or as	a conseq	uence of):						
B	nat the death certificate be ex d by the attending physician detached for use as the buria	by Physician/Med	IF FEMALE: 23b. Was deceder in the past 1: 1  Yes 2: 9  Unknow	2 months? No	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 🗌 Feta	al death 3	☐ Ectopic pregnan ☐ Other (specify)	cy .		23	d. Date of deliv	very Day Year
ds, P.O	and be		_	nificant conditions	ontributing to death	but not res	sulting in the	e underlying cause (	given in Part I.			e contribute to	the cause of death? bably 4 Unknown
Division of Vital Records,	ne law has b ige 2 s	Completed								24a. Was auto perf 1 X Yes	s an opsy formed? 2 \( \sum \text{No}	death?	opsy findings available ompletion of cause of
Vital	ician: ertifica rector,	Be	25. Was case referenced examiner?		Hospital: 1 X Inpat	ient 2	EB/Outpati	ent 3 DOA Ot	26. Place of De	ath (Check only		Other (Speci	
on of	ng Phys ter this ineral d	tion: To	1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	28a. Date of Inj (Month, D	ury	28b. Time Injur	of 28c. Inju		28d. Describe			
Divisi	I or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 4 Homicide		building, e	tc. (Specif	fy)	street, factory, office		City or To	own, State)		ral Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Medical C	29a. Certifier (check only one)	1 Certifying Pi 2 Medical Exa	nysician: To the best miner: On the basis and manner	of examina	owledge, de ation and/or	ath occurred at the investigation, in my	time, date and place opinion, death oc	ce, and due to th curred at the tim	e, date and	place, and due	
_	To the within 2 To the comple	Me	29b. Signature/ar		M.D.				se number $S - O($	00	29d. Date	signed (Month	, Day, Year) 2009
			30. Name and ad	Idress of person who	completed cause o	f death (Ite	em 23a) (Typ	e, Print)	600	North W	olfe St	, Baltimo	ore, MD, 2128

State Registrar

DIL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician**  $P^{M}$ 1643 June 2009 Rosemary Straughan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 SunBridge Care Center E1kton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs March 15, Arkansas 81 457-34-7238 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedfort Examiner must be notified at once. 10a. State 1 ☐ Yes 2 No Directo E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 3208 Old Elk Neck Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: Specify: <u>۾</u> White 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Thomas Mattie Irene Harper ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 129 East Main Street, Walnut Bottom, PA 17266 Robert P. Straughan/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Gilpin Manor
Memorial Park June 26 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hicks Home for Funerals, 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prieumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an s certificate has be irector, page 2 sl 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 12 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P.V. Narye ? D0065733 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKTON, MD 21921 V. PULA Smeet A E. HIGH 126 NARATANA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Elizabeth J. Villa 09 092330 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace
 Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F Months Days Hours **Director** 102-20-0407 December 26, 1913 Pennslyvania 1 4 1 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No **Funeral Director** Allegany Frostburg Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17311 Porter Road, S.W. U.S.A. 21532-12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Completed by 3 ¥Widowed 4 ☐ Divorced White other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Bobick Anna Couch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Power of Attorney Maryland Edith Ritchey 17301 Windcrest Lane Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury 4 Donation 5 Dother (Specify) June 12, 2009 Frostburg Frostburg Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death Hint 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ 1√0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours are To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thas 1221 E nanno 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 12 2009 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OG **Physician** ATHLEEN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Date of Birth (Month, Day, Aug 22 9. Birthplace (State or Foreign Birthpia Country) MD . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year Months 1 □ M 2 □ F Yrs 1924 219-14-6666 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinet must be notified at MD Allegany Cumberland 1 Tyes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 13 Browning Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_2 \_\_No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by white 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Stickley Long Ralph Long ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
114 Stonegate South Boerne TX 19a. Informant's Name/Relationship (Type. Print) 78006 Sue Wayland daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department c Important: If any injury or once. 6/13/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nobable Immediate Cause (Final 2 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ corona 1 ≥ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes → No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 ☐ DOA . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tile of 29c. License number

State Registrar

2

MIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Şignature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year **Physician** <u>8:5</u>7₽ <sup>™</sup> 15 2009 Eugene June Wright Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 52 West Branch Circle North East Ceci1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 XM 2 ☐ F Months Days Hours 44 222-50-5652 Feb. 12, Director 1965 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" > 12-12 maryland any highly or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 7 Stayman Dr. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 📉 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify. White Specify: þ 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Programer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Allen Wright Carol Lee Overstreet 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Licht/Personal Rep. 52 West Branch Circle, North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, Maryland 21. Signature of Funeral Service License 22 Name and Address of Facility
R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a Part 1. Enter the disease, or composhock, or heart failure. List only of Immediate ause (Final disease condition resulting leath) Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 ₹No 5 ☐ Residence 6 ☐ Other (Specify) this eral Director: After th filled in by the funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle 29c. License number 30. Name and oddress of perion who completed cause objeath (Item 23a) (Type, Print) 6 M. Hosford-Skapof, M.D., 111 W. High St., Suite 104, Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 17 2009 Registrar

_		State Registrar			Cei	rtificate of	Death		Reg. No	200	0 200
cia dica		Decedent's Name (First, Middle, Last)     HOMER ALI	LEN WALKU	JP				2. Date of D Month JUN	Da	ay Year	3. Time of Dedth /
ine		4a. Facility Name (If not institution, give str				4b. City, Town, o	r Location of D	eath	40	. County of Deat	
ı		NATIONAL NAVAL MI	EDICAL CI	ENTER			BETHESI				OMERY
Г		5. Social Security Number 6. Sex	7. Age И 2□ F	(In yrs. last bi		If Under 1 Year Months Days		Ain. (Month, D	irth Da <i>y, Y</i> ea <i>r,</i>	9. Birti	hplace (State or Foreig untry)
	-	235-62-7951 Usual Residence of Decedent		92	Yrs.			Jan.2	8, 1	917 West	. Virginia
	_	10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits 1 X Yes 2 □ No
		Virginia None  10e. Street and Number		Ale	xand	dria 10f. Zip Code			10g Ci	itizen of What Co	
1		4800 Fillmore Ave.				2231	1		, og. 01	USA	, ·
	Funeral		. Was Decedent B	ver in U.S.	13. \			? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Ame	
h., 61	by rui	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 ∑Yes 2 □ N  If Yes, Give Year or Dates:	0		lfYes, specify Cuba 1 □Yes 21X1No	an, Mexican, P Specify:	uerto Rican, etc.)		Black, White	a, etc. nite
	Completed	15. Decedent's Educa (Specify only highest grade of	tion	16a	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of	working	16b. H	Kind of Business/	Industry
	E C	Elementary/Secondary (0-12)	College (1-4or 5	+)			u)			US Nav	7
		17. Father's Name (First, Middle, Last)	<del></del>	l	1	Lawyer	18. Mother's	Name (First, Middle	e, Maidei		/
	To Be	Homer A. Walkup,	Sr.				Lil	lie Belle	Har	ris	
		19a. Informant's Name/Relationship (Type	e. Print)			-		r Rural Route Num	_		
		Pamela Walkup- Daug	ghter					Alexandr			
		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Rea	moval from State	1		sition (Name of matory or other plac	i i	Date		_ocation - City or	
	-	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fune al Service Licensee		Ever		Crematory		/17/2009		xandria,	
		21. Signature of June al Service Licensee						Everly Wh < Rd.,Ale			
	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	PESS a consequence a consequence a consequence	of):	Z CANCER					
	hysician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome  1  Live birth  4  Pregnant at 9  Unknown	2 🗀 Fetal deatl		☐ Ectopic pregnanc ☐ Other (specify) _	гу			23d. Date of del Month	livery Day Year
	by P	Part II. Other significant conditions contr	ibuting to death bu	ıt not resulting i	in the u	nderlying cause giv	en in Part I.				the cause of death?
	Completed							24a. Wa aut per	s an opsy formed?	24b. Were au prior to death?	utopsy findings available completion of cause of
	Be C	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		lo   I les	2 2 110
,	2	examiner? 1 ☐ Yes 2 No	spital: 1 Xinpatie	nt 2 ER/O	<u> </u>		ner: 4 🗆 Nursii	ng Home 5 ☐ Re	sidence	6 ☐ Other (Spe	ecify)
		27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day		Time of Injury	Wor	ryat rk? ]Yes 2∐No	28d. Describe	e how inju	ury occurred	
į		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulg	iry - At home, fa	arm, str	reet, factory, office		28f. Location City or To	(Street a	and Number or Ru te)	ural Route Number,
ı	ertific		nian: To the heet								
	dical Certification:	29a. Certifier 1 XCertifying Physic (Check only one) 2 Medical Examine		ted.					001.0		
3	Medical Certific	(Check only 2 Medical Examine	er: On the basis of	ted.		29c. Licens		(7/4)	29a. D	late signed (Mont	
	edical	(Check only 2 Medical Examine one)	er: On the basis of and manner sta	- mi	(Type,	0101	245663		15	June	2009
	edical	29b. Signature and title of certifier	er: On the basis of and manner sta	- mi	CType,	0101	245663 NAT	(VA) CIONAL NAV	/5 VAL 1	June	2009

			1 - For State Registrar	State of Maryland / [		artment tificate			ind M	Re	eg. No.	009	209	
	Physicia	an	Decedent's Name (First, Middle, Last)							2. Date of Deat Month	9 pay	2ŎO9	3. Time o	
	/Medic		Fred	Young					( D - + 1)	June				
	Examin	er	4a. Facility Name (If not institution, give			4b. City, To		Cha				ntgom		
			Manor Care Che 5. Social Security Number 6. Sec		thdav)	If Under 1		If Under 2		8. Date of Birth		9. Birth	place (State	or Foreign
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	D .		Usual Residence of Decedent											Na. 12-22-
	arylar show	_	10a. State 10b. County N/2	10c. City, Town									10d. Inside C	2 □ No
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	with t	Ö	10e. Street and Number	- L W 70		10f. Zip C		2		'		S.A.	and y :	
	leath ns 23	Funeral Director	318- E - Stre	12. Was Decedent Ever in U.S.	13. V		000 nt of His		gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer		
(O	ifter of	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		_			, Puerto	Rican, etc.)		Black, White	_	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ad other then "naturel", or Items 23a or 28a-f show event, it is Modrel Examinar muttos motified at	l by	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	1□Yes 2□	<b>X</b> No	Ѕреспу:			Sp	pecify: Bl	ack	
2	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	tent's Usual ( kind of work	done de	uring most	of worki		16b. Kind	of Business/I	ndustry	
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au	m - 0 5	To Be								eth Yo				
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	-	19a. Informant's Name/Relationship (T)	rpe, Print) 19b	. Mailin	ng Address (	Street a	nd Numbe	r or Rura	l Route Number	, City or T	own, State, Z	ip Code)	
Σ	and 2 valth a 127 ls		Freddie Young	/Son 3	18-	- E -	st	1	IE .	Wash.	DC	20002		
ore	of He fitem		20a. Method of Disposition  5☐Burial 2 ☐ Cremation 3 ☐ F	20b. Place of cemeter	f Dispo: ry, cren	sition (Name natory or othe	of er place	)		17	20c. Loca	tion - City or	Town, State	
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic a once.	i	21. Signature of Funeral Service Licens	Hacket An.	22	Hack 814	Address ett Ups	s of Facilit S E hur	une St.	ral Ch	apel C 2	6011	•	
			23a. Part 1. Enter the disease, or complete chock, or heart failure. List only o	ications that caused the death. Do not cause on each line.	not ente	er the mode	of dying	, such as	cardiac c	or respiratory arr	est,		Approxima Interval Be Onset and	tween
	Pnysician		Immediate Cause (Final disease or condition	Failure To	Thi	rive							Onost and	Joan.
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):									
		-F	Sequentially list conditions, if any, leading to immediate	b. Dementia Due to (or as a consequence	of):									
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	-										
ó	an an	Еха	resulting in death) Last	Due to (or as a consequence	of):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d										
9	entifica ing ph e as t	Physician/Med	IF FEMALE:											
Вох	eath certific attending p for use as I	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death		Ectopic preg					230	<li>d. Date of deli Month</li>	very Day	Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	2	Other (spec	JIIY)							
<b>Q</b> _	res that igned by be deta	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in	n the ur	nderlying cau	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of	death?
ecords,	quires n sign									1 🗆 Y	es 20	Mo 3□Pr	obably 4	]Unknown
000	aw requir is been si 2 should	Completed								24a. Was a		24b. Were au	topsy findings	available
$\alpha$	The lav	lwo								autops perfor		death?	2 <b>½</b> No	Cause of
Vital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only or				
of <	Physicien: r this certifica ral director, i	To	1 ☐ Yes 2€ No	fospital: 1 ☐ Inpatient 2 ☐ ER/Ou	itpatien			4 <b>X</b> Nu		me 5 Reside			cify)	
	ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 ☐ Pending		Time of njury		c. Injury Work			28d. Describe h	ow injury o	occurred		
Sio	Attending r death, ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	Of a Plane of Jaium. At home to		M		′es 2□.		28f. Location (S	troot and I	Number or Ri	im I Pouto Nu	mhar
Division	Dir	Certification;	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	iiii, sii	eet, ractory,	OIIICO			City or Town		VB///DG/ C// 1/0	74, 7,00,0,140,	mbor,
	To the Hospital within 24 hours of To the Funeral I completely filled	edical C		sician: To the best of my knowledge ner: On the basis of examination an and manner stated.										(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date	signed (Monti	h, Day, Year)	
)			1 Cm	200 / MD			D00	5712	24	C	6-1	7.0	9	
-	6		30. Name and address of person who correct Truong Bao, M	.D. 10110 Mole	cu]		r.	S 20	6 R	ockvil	le,	Md 20	850	
	Sta Registr		JUN 1 7 2009	32. Registrar's Sanature	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 30 10:2 **Physician** JAMIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital 5. Social Security Number N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1-8-1944 Director UAE 65 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director UAE Abu Dhabi 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code N/A P. O. Box 6168 Arab or items 23a Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 XYes 2 No Specify ģ Yes. Gir 3 Widowed 4 Divorced Arab Year or Dates Arab 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education N/A (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+N/A Elementary/Secondary (0-12) Self employed Pages 1 and 2 should be filed and the filed and Mental Hygicint: If tem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Khalifa Al-Khaili Wanea Khaili 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salaha Al-Amime-Wife 6168 Abu Dhadi, U A Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department of
Important: If it
any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Family Plot 7-6-2009 Abu Dhabi, U A E 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H la Warren 1101 E. North Avenue Balto, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 515 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit and resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be exec Box 68760, nding physiciar Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 **N**0 3 Probably 4 Unknown 1 Tyes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tes Yes Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident within 24 hours after death To the Funeral Director: A 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie RES-000 2009

State Registrar 31. Date filed (Month, Day, Year)

We.

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

ORIGINAL

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

			1 - State Registrar	State of Marylan	•	rtment of F			giene Reg. No. 20	09	20977
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
П	Physici /Medic		Edward Blaine All	lis				June 21	, 2009		11:00 PMM
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dear	th	4c. County		
			6801 Accipiter Dr	rive		New Mar				eric	
i	Funeral Director		405-07-0325	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1922	9. Birthi Cou Ken	place (State or Foreign ntry) tucky
	D 3		Usual Residence of Decedent  10a, State 10b, County	10c Cit	v. Town or Lo	cation					10d. Inside City Limits
	eho e o	2			,						1 ☐ Yes 2 ☑ No
	the h	Director	MD Frederick  10e. Street and Number	New	Marke	10f. Zip Code			10g. Citizen of \	What Cou	intry?
	with a	ā	6801 Accipiter Dri	W.O.		21774			USA	-1101	,
	leath	era		2. Was Decedent Ever in U.	.S. 13. V		lispanic Origin? (S	Specify Yes or No-		e - Amer	can Indian,
38	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23s or 28s-f show aumstic event, the Medical Exactionation and the another at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☑ Yes 2 ☐ 1942 - If Yes, Give 1942 - Year or Dates: 1945		Was Decedent of H f Yes, specify Cubi 1 ☐ Yes 2X No	Specify:	to Rican, etc.)	Blac	ck, White, <sub>v:</sub> Whit	, etc.
ş	2 hou	Completed	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup	atiorunk		16b. Kind of B	usiness/lr	ndustry
215	hin 7 9. "n Medi	pie	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	kind of work done OO NOT use retire	during most of wo	nrking			
21	d wit	Ю	9	0					printin	g	
g	0 m 5 5	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Suman	18)	
<u> a</u>	Wents Wents wrked rrked	2	Edward Allis				Edith T	hompson			
a	2 sho and I ie ma		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or R	ural Route Numbe	ar, City or Town,	State, Zi	p Code)
2	カモトラ		Dorothy Allis/spou	se	6801	Accipite	r Drive	New Mark	et, Mar	yland	1 21774
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 ie marked eny Injury or other traumatic e pace.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☒ Donation 5 ☐ Other (Specify)	_	Place of Dispo emetery, crer	sition (Name of natory or other plai	ce)	Date	20c. Location	City or T	own, State
Balt	permit. Departrimports Imports eny inju		21. Signature Funeral Service License	Mirector		Name and Address ate Anat ltimore,	_		Baltim	ore S	Street
	Physician		23a. Parti. Enter the disease or complic shook, or heart lailure. List only on Immediate Sause (Final disease or condition	cations that caused the deat e cause on each line.		er the mode of dyir	ng, such as cardia		rest,		Approximate Interval Between Onset and Death
,	/Medical Examiner		resulting in death)	Due to (or as a conseq							
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):						
8760,	cate be executed physicien and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a conseq	uence of):						
9	eath certifica attending ph for use as ti	/Med	IF FEMALE:	Po If yes autooms of progns	1001			========		anoser	
O. Box	death e atte	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of depth of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the s	I death 3	Ectopic pregnancy Other (specify)	/			ite of deliventh	very Day Year
	res that the de signed by the a be detached t	y Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use con	tribute to	the cause of death?
ğ	w require been sig should b							101	res 2 No	3 ☐ Pro	bably 4 🗍 Unknown
Vital Records,	The ta ate has page 2	Completed							rmed?	Were aut prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
<u>ıta</u>	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o	опе)		
	Physic this o	2	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	it 3□ DOA Ott	er: 4 ☐ Nursing	Home 5 Resid	dence 6 Ott	ner (Spec	ify)
Division of	ttending Ph death. ctor: After th y the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	yat rk?  Yes 2∐No	28d. Describe I	how injury occur	red	
DIVIS	selor Attense effer deat	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, larm, str y)	eet, factory, office		28l Location (S City or Tox		er or Rui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours eller death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my kno lar: On the basis of examina and manner stated.	wledge, deat tion and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
)	with To t	2	29b. Signature and title of certifier Ames	merena 1	n D	29c. Licens	03642	.(	29d. Date signe	123/	() Day, Year)
			30 Name and address of person who con	mpleted cause of death (Item			Dr. #10	y Fred	lorist	Mi	21721
	Sta		31. Date liled (Month,-Day, Year)	32. Registrar - Signa	ature	tield	13/3 10	1 1100	rei ich	1110	, , , , , ,
	Registr	ar	nn 11 77	MO Museum	A. 4	Tal Car					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 26 ROSE **ABERBACH** 2009 9:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LORIEN MAYS CHAPEL NURSING HOME LUTHERVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/07/1910 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F Months 98 NY 215-28-9771 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the tradical Examiner must be notified at 1 ☐Yes 2 No Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4730 ATRIUM COURT 21117 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN **GALANTER** NATHAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if item 27 any injury or other tragnes. 7923 WINTERSET AVENUE, BALTIMORE, MD 21208 LINDA HANKIN / DAUGHTER 20b. Place of Disposition (Name of ARIMING TONIO CHILLURCE) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/28/2009 BALTIMORE, MD AMUNO CONGREGATION 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signal e Funera Service Acensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 7 DAYS NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause [Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à REFLUX DISEASE icate has been siç , page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Was a.. autopsy performed? Yas 2 □ No 24a. Was an certificate has 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner's Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No o the Hospital or Attendi thin 24 hours after death. The Funeral Director: A 2 Accident by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and time of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053095 JUNE 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEXAS STATION Cr. #210, Timonium, MO 21093 J. CARR, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			State of Maryland Depart 1-State Registrar 19b per fh Certi	ment of 1935 ficate of De	a <b>lth /1011/109</b> eath	Hygie Reg.	ne No. 2009	20979
	Physici	an	1. Decedent's Name (First, Middle, Last)		2	Date of Death Month	Day Year	3. Time of Death
A	/Medic		Melvin Frederick Blanchard	. O' T	and an of Decath		28 2009	5:45 AM M
	Examir	ner	4a. Facility Name (If not institution, give street and number)  Upper Chesapeake Medical Center	b. City, Town, or Lo Rel Air	Maryland	_	4c. County of Death Harford	
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year   If		Date of Birth (Month, Day, Ye		place (State or Foreign
	Director		219-01-0972	Months Days I		05/28/19		yland
	and		Usual Residence of Decedent  10a. State	ion			1	0d. Inside City Limits
	Maryk fsho jedal	Ö						1 □Yes 2 No
	r 28a- notif	Director		10f. Zip Code		10g.	. Citizen of What Cour	ntry?
	h with		506 Plumtree Road	21015		1	U.S.A.	
	r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Years 15 Y	s Decedent of Hispa es, specify Cuban, I	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
9	36 s afte		1 Nover Married 2 M Married 1 X Ves 2 No	3.7	Specify:		Specify:	_
8	5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ted t	15 Decedent's Education 16a, Deceden	t's Usual Occupation	on	168	Whi b. Kind of Business/In	
	Z15 Ele.	plet	(Specify only highest grade completed) (Give kin life. DO Elementary/Secondary (0-12) College (1-4or 5+)	d of work done duri NOT use retired)	ing most of working			
8	d Z1Z1	Completed by	12 5 Atto				elf-Employ	red
2005	aryland aryland should be file and Mental H is marked oth	Be	17. Father's Name (First, Middle, Last)		3. Mother's Name (			
28	aryla should I and Men s marke umaffc	은	Edward Melvin Blanchard  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing &				eth Spies	Code)
5:	and 2 s and 2 s ealth an n 27 is I		Patricia A. Sullivan (daughter) 506	lumtree	Road - I	Rel Air.	ity or Town, State, Zip Marvland	21015
3	s 1 ar	-	20a. Method of Disposition 20b. Place of Disposition		Dat		c. Location - City or To	own, State
	Pages Pages nent of ant: If it		1		07/01/	2009 Ti	imonium, M	aryland
7	BAITIMOYE, Maryland 21215-UU36 per nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. N	lame and Address of	of Facility $\mathbf{E}_{ullet}$	. Lassa	hn Funeral	Home, P.A.
1/	D S Z C Z						le, Maryla	
45			shock, or heart failure. List only one cause on each line.		such as cardiac or		.,	Approximate Interval Between Onset and Death
1	Physician /Medical		resulting in death)	ABOLIC	1-tCIDO	212		
	Examiner		Due to (or as a consequence of):	PSIS				
ا _		Jer	if any, leading to immediate Due to (or as a consequence of):	1313				
12.	Transi	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events  c. ABDOM; NAC 2	ISCHE	MIA			
es es	be exection a		resulting in death) Last  Due to (or as a consequence of):					
5	Hecords, P.O. Box b8/bu, C.  The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical	d					
Di	OX C		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deliv	erv
ar	death death e atte	Physician/M	in the past 12 months?  1 Ves. 2 No. 4 Pregnant at time of death 5 0	ctopic pregnancy ther (specify)			Month	Day Year
ch	at the	hys	9 ☐ Unknown					
Blancha	cords, P.O.  w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the unde	erlying cause given i	in Part I.		cco use contribute to t	he cause of death? bably 4 🗌 Unknown
De	requi	eted						
	VITAI HECOTAS, lcian: The law requires t certificate has been signs rector, page 2 should be o	Completed				24a. Was an autopsy performer	prior to co	opsy findings available impletion of cause of
	VITAL MENICIAN: Incian: The laver certificate has rector, page 2.		25. Was case referred to medical	0.	6. Place of Death (	1 □ Yes 2 X	No 1 □Yes	2 🗆 No
	OT VITA Physician: r this certificiral director, pr	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor			ce 6 ☐ Other (Speci	fv)
77	On OT  Jing Phys  After this funeral di	n:T	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	28c. Injury a Work?		d. Describe how		
à.	VISION Attending r death. ector: After	catic	2 Accident investigation	M 1 □Ye	s 2 No			
M800403922	= 5 ± 5 =	Certification: To	4 Homicide determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office	28	f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
3	lospital of hours a uneral D		29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death or	ccurred at the time.	, date and place, ar	nd due to the cau	se(s) and manner as	stated.
\ \ \ \	the Hos hin 24 h the Fur npletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opin	nion, death occurred	at the time, date	e and place, and due t	o the cause(s)
2	To the I within 2 To the I complet	M	29b. Signature and title of certifier	29c. License n	umber	29d	Date signed (Month,	Day, Year)
	inth		Datricea guruma	D26:	344	V	INE 28,	2009
	D.		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	nt)	0 12-1 4	200	IN I	
10	Sta	ite	Patricia Gurny M.O. 500 Uner Chesage 31. Date filed (Month, Day, Year) 32. Registral Signature 33. Registral Signature	UKEUN	C DEI AI	, NO 2	1014	
29g	Registi	ar	31. Date filed (Month, Day, Year) 32. Registrate Signature.					

DHMH 17 Rev 1/2001

240-299

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event, the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event and the Modical Examine traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event eve

Baltimore, Maryland 21215-0036

Physicían /Medical Examíner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

1			,								1			
r	4a. Facility Name (If not ins HARBOR			er)			Town, or		of Death		40	c. County of Dea	ath	
	5. Social Security Number <b>22094-7163</b>	1	Sex 7. ▼ M 2 □ F	Age (In yrs. I	ast birthda Yrs.	y) If Unde Months		If Unde Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D) Feb 2,	rth ay, Year 19	9. Bi 73 Mar	rthplace <i>(St</i> ou <i>ntry)</i> cyland	ate or Foreign
	Usual Residence of Decede			10c City	, Town or I	ocation							10d Insid	le City Limits
_		Julity		100. 010										Yes 2 □ No
ž	MD				Balt	imore								
<u> </u>	10e. Street and Number	_				10f. Zij					10g. C	itizen of What C	ountry?	
neral Directol	608 E. Jef	frey	Street				21	225				USA		
<u>=</u>	11. Marital Status		12. Was Decede Armed Force		S. 13	B. Was Dece	dent of H	ispanic C	origin? (Spe	ecify Yes or N Rican, etc.)	D-	14. Race - Am Black, Whi		n,
ב	1 X Never Married 2 □	Married	1 ☐ Yes 2			1 ☐ Yes		Specif				Specify: W		
6	3 ☐ Widowed 4 ☐ Div	orced	Year or Date	es:		1 🗆 100	-A-1110	Ороон	,.			Specify. WI	IILE	
mpieted by			ducation ade completed)		(Giv	cedent's Usu we kind of wo DO NOT u	ork done d	during mo	st of worki	ng	16b. I	Kind of Business	s/Industry	
E	Elementary/Secondary (0 12	-12)	College (1-4	or 5+)			dis	sable	ed			none		
0	17. Father's Name (First, M.	ddle, Last,	)	1				18. Mot	her's Name	(First, Middle	, Maide	n Surname)		
Ď	Richard L.	Brad	field					Lo	orrai	ne Krau	ıch			
=	19a. Informant's Name/Rela				19b. Ma 509	iling Address Vista	s (Street a. Ave	and Num	ber or Rura Glen	al Route Numb Burnie	per, City	or Town, State 21061		
	20a. Method of Disposition	ution 2 [	Romaval from Sta	.   C	emetery, cř	position (Na.	other plac			ate	20c. l	ocation - City o	r Town, Stat	e
	4 □ Donation 5 X Ott	er (Specif	) in stat	e Arge				1	· ·	/2009	Har	nover, M	Maryla	nd
	21. Signature of Funeral Se	rvice Licer	Wade, Di	fector	S B	<sup>22.</sup> Name a tate <i>A</i> altimo	\natc	omv F	<sup>ility</sup> Board 21201	655 W.	Ва	ltimore	Stree	t
	2 a. Part . Enter the disea shoo, or heart failure Immediate ause (Final	se, of com List only	plica ons hat cau one cause on eac	h line.	. Do not e		de of dyir	ig, such a	as cardiac	or respiratory	arrest,		Approx Interva Onset	imate I Between and Death
	disease or condition resulting in death)	-	a. Due to (or	as a consequ	ience of):								-	
	Conventiols, list conditions	•	h A	CUTE	R	ESPI				FAILL		E	$\approx 2$	weeks
0	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (or	as a consequ	ionice of):			(	<b>\</b>	M. A	ALL SYA	MINER		
Ya	that initiated events resulting in death) Last	1	c	as a consequ	ence of):				THI APP	OVED BY MED	CALEN		ļ	
<u>é</u>		ı	٠ ١ (٠.					CERTIFIC						
Ś			a											
ysicializm	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			h 2 ☐ Fetal nt at time of d	death 3	B ☐ Ectopic p i ☐ Other <i>(s</i>		у				23d. Date of de Month	elivery Day	Year
=	Part II. Other significant co	nditions o	ontributing to deat	h but not resu	Ilting in the	underlying	ause giv	en in Pari	t I.	23e. Did	tobacco	use contribute	to the cause	of death?
5	MORBI		OBES			, ,	J			1 🗆	Yes :	2 <b>5</b> No 3□ F	Probably 4	I ☐ Unknown
חובום	ACUTE		KIDNE	Y	L N I	URY	du	e to		24a. Was		24b. Were a	autopsy find	ings available of cause of
5	Hypote	nsion								perf	ormed?	death?	/	
	25. Was case referred to me examiner?	edical								(Check only				
2	1 <b>X</b> Yes 2		Hospital: 1 Inp			ent 3 □ D	OA Oth	er: 4□!	Nursing Ho	me 5 ☐ Res	idence	6 □Other (Sp	ecify)	
alloii.		ending vestigation		Injury Day, Year)	28b. Time Injury	of :	28c. Injur Worl	yat <br Yes 2[		28d, Describe	how inj	ury occurred	-	
	3 ☐ Suicide 6 ☐ C	ould not be etermined	20e. Place of	Injury - At ho etc. (Specify	me, farm, s	street, factor	y, office			28f. Location City or To	(Street a	and Number or F te)	Rural Route	Number,
200	29a. Certifier 1 Certifier (Check only one)	tifying Ph dical Exar	nysician: To the be niner: On the basi and manner	s of examinat	wledge, de	ath occurred investigation	at the tinn, in my c	me, date pinion, d	and place, eath occur	and due to th	e cause , date a	(s) and manner and place, and du	as stated. ue to the car	ıse(s)

State Registrar 31. Date filed (Month, Day, Year)

ANUPA

29b. Signature and title of certifie

BARAL,
32 Registrar's Signature

(MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 S HANOVER STREET, BALTIMORE, MD 21225

29c. License number

000

29d. Date signed (Month, Day, Year)

JUNE, 12,2009

3

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 23:35 Joanne Marie Berry JUNE 29 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPITAL AGNES BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, June 20 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2√2 F 70 216-34-4046 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 21 No Baltimore Maryland Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 5833 Oakland Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Buker Gertrude Baer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5833 Oakland Road Halethorpe, Maryland 21227 John T. Berry, Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 🗆 Removal from State Metro Crematory Inc. 07/01/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition INTRAVASCULAR COAGULATION DISSEMINATED 10 HRS

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a M. Jon Every increment any injury or other traumatic event, If a M. Jon Every increment and any experiment.

Baltimore, Maryland 21215-0036

burial-transit se as t sate has been signed by the page 2 should be detached

within 24 hours after death.

To the Funeral Director: A

	.O. Box 687	the death certificate
RY, JOANNE	Division of Vital Records, P.O. Box 687	or Attending Physician: The law requires that the death certificate
BERRY	<b>Division</b>	or Attending

	resulting in death)	Due to (or as a consequence of):				
L	Sequentially list conditions.		TRANSPUSION	15		
nel	if any, leading to immediate	Due to (or as a consequence of):				
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. INTRIOPERATIVE	BLEEDING			
Ä	resulting in death) Last	Due to (or as a consequence of):				
<u>6</u>						
lë ë	-	, d				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Ye	ar
흐	Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tobacco	use contribute to the cause of de	ath?
ed by	HYPOTENSION, COR	RONARY ARTERY DISEASE,	MI, CORONARY	1 □ Yes	2 No 3 Probably 4 Ur	ıknown
mplet	STENTS			24a. Was an autopsy performed	24b. Were autopsy findings av prior to completion of cau death?	vailable use of
ပိ				1 □Yes 2√2N	lo 1 □Yes 2 □No	
Be	25. Was case referred to medical examiner?	Us solvely		ath (Check only one)		
2	1♥Yes 2□No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing H	lome 5 Residence	6 ☐ Other (Specify)	
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work?	28d. Describe how inj		
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Numb te)	er,
Medical Certification:		nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.				
ž	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Day, Year)	
	<b>▶</b> (1) →	MD	P23574	6	136109	
	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)				
	DR. CALVIN DA	VID ST. AGNES HOSP	MAC BALTIMO	Rt, MD		
ate	31. Date filed (Yon') 17, 2009	A 32. Begistrar's signature				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June June **Physician** 2009 ar 29, 11:00 A M Victor Biezenski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 405 Teal Ct Chester Queen Anne's | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 4, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F Months 105-24-0043 92 Yrs. Austria Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinant must be a wiffed at 1 ☐ Yes 2 No Director Queen Annes Chester Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21619 405 Teal Ct Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stock Broker Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Zawirowska Victor Zbigniew ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 405 Teal Ct. Chester, Maryland 21619 Irene Biezenski, Wife Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. | 06/30/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** o lon Ĺ Metestatio 4260 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 I Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onl one) 29b. Signature and til of certifies 29c. License number 29d. Date signed (Month, Day, Year) 37064 09 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stevensville 21666 un en (97

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 1 per doc 8893 7-1-09 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Janet Smetana Hicks Brandon Month Year **Physician** 7:20 P M 25 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F 216-34-2466 Maryland Director 72 March10,1937 Usual Residence of Decedent of Health and Mental Hygiene. "natural" ~ "- cuds of Health and Mental Hygiene." inatural" ~ "- cuds of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 □Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Rd. 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2XINo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 🖾 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Wensclaus Smetana Geraldine Catherine Bursick ပ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy H. Stevens - daughter 185 Pheasant Run Ln., Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 6/27/2009 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home largue 310 Church St., New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Inderion **Physician** 1122 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 □Ýes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA this Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JEGS 3502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Stephen J. Sikorski

JUL 0 1 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

912 Washington Rd.

Westminster, MD 21157

			_ For	State of Mary	yland / Depa	artment of H	lealth and	Mental Hyg	iene	
	_		State     Registrar		Cei	rtificate of	Death	R	eg. No. 🤈 🕦 📫	0 20001
	Physici		1. Decedent's Name (First, Middle, La Margaret	Loui	se	Bust	er	2. Date of Deat Month 06	Day Ye. 25 200	
0	/Medic Examir		4a. Facility Name (If not institution, given 1323 Robin Roa	e street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of D	
	Funeral		Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9	Birthplace (State or Foreign Country)
	Director		213-22-0933	□м 2√Д Г	Yrs.	Months Days	Hours Min.	06 10		NC NC
	and		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	호		kesville	,	Baltim	ore			1 □Yes 2 No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	th with	a D	1323 Robin Roa	Ē		21	208		U.S	.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm, Machail Evanime must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of H f Yes, specify Cuba l □Yes 🎎 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, /hite, etc. Black
21215-0036	n 72 hou " <b>natur</b> a	oleted	15. Decedent's Ec (Specify only highest gra	de completed)	16a. Deced	dent's Usual Occup kind of work done OO NOT use retired	oation during most of wo	rking	16b. Kind of Busine	•
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, Maryland	and 2 sho salth and 1 27 is m er traum	100	19a. Informant's Name/Relationship (William Mitche)	**	I				; City or Town, Stai s Mills	re, Zip Code)  • Md 21117
Baltimore,	ages 1 a ent of He ent of He ent of He ent of He ent of He ent of He ent of He ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of he ent of		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	Removal from State	20b. Place of Dispo	sition (Name of natory or other place) d Ridge	;		20c. Location - City  Pikesvi	
3altii	permit. F Departm Importar any injur		21. Signature of Funeral Service Licer		1 22 N	Name and Addre	ss of Facility	.709	FIRESVI	ile, mu
	<u></u>		25a. Part 1. Enter the discount com	X005-X1	which 4	1300 Wab	ash Ave		imore, M	1d 21215 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	te (	ance		c or respiratory arr		Interval Between Onset and Death
D.		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a c	onsequence of):					
8760,	ficate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
O. Box 6	Physician: The law requires that the death certificate this certificate has been signed by the attending rat director, page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particle in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	Fetal death 3	Ectopic pregnanc	ey		23d. Date of Month	delivery Day Year
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of Vital Records,	he law rec e has bee age 2 shou	mplete						24a. Was a autops perfori	ned prior	e autopsy findings available to completion of cause of h?
ta	an: T tificat tor, pa	Be Co	25. Was case referred to medical				26 Place of De	1 □Yes ath (Check only on		Yes 2□No
>	nyslci lis cel direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or,		ence 6 Other (	Specify)
o uoi	nding Pf th. :: After the funeral	tion:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Y	(ear) 28b. Time of Injury	Wor	ry at k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not b determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number o n, State)	r Rural Route Number,
	he Hospit in 24 hour ne Funer: pletely fills	Medical (	29a. Certifier  (Check only one)  Certifying Pt  2 Medical Example	ysician: To the best of r niner: On the basis of ex and manner stated	amination and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the durred at the time, d	eause(s) and manne late and place, and	er as stated. due to the cause(s)
	To the within to the company of the the the the the the the the the the	Ň	29b. Signature and title of dertifier			29c. Licens	0594	79 2	9d. Date signed (M	fonth, Day, Year)
	6		30. Name and address of person who	completed cause of deat	nD-37	Print) 230 Fall	sRoad	Balti	none N	11216.01
	Sta	te	31. Date filed (Month, Day, Year)	n negistial's	Gigilia di G	00 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1842 M **Physician** BACON 2009 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Mospita Northidest andalls town Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2/CXF Months Days Hours Min. 78 SEPT 21 1930 NORTH CAROLINA Director 093-24-0582 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, Ite Medical Event net has natified at 1 ☐ Yes ZXNo Director RANDALLSTOWN MARYLAND BALTIMORE CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 9824 CLANFORD RD 21133 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married aryland 21215-0036 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: Specify. Specify: BLACK <u></u> 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Itel Maone. Elementary/Secondary (0-12) EQUITABLE LIFE CO College (1-4or 5+) 12th grade CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ NOKOMIS CARTER GLADYS JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Clark/Daughter 9824 Clanford Rd., Randallstown, Md., 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 07-03-09 LANSDOWNE, MARYLAND 21. Signature of Funeral Source Censee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 3\_da/5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) ere /Medical Due to (or as a consequence of): Examiner tromboemb if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transi Records, P.O. Box 68760, ~ and Due to (or as a consequence of attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) 9 Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> icate has been siç r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed certificate Vital 1 ☐ Yes 2 ☐ No 1 ∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Divisi filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 29a. Certifier 1 💪 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and

DHMH 17 Rev 1/2001

Kandoilstown, MJ

son who completed cause of death (Item 23a) (Type, Print)

Koad

H0068505

UNE 28, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #12 Per FB 6893 7/08/09/ Ellipartment of Health and Mental Hygiene

			1 - State of Maryland / Department of Health an Certificate of Death		Reg. No. 2009 20986
	Physicia		1. Decedent's Name (First, Middle, Last)  Mary, Bromble	2. Date of D Month	Peath Day Year 3. Time of Death 3 % M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  Anne Anndel Medical Center Annapolis	Death	4c. County of Death Anne Arundel
	Funeral Director	ī	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If	Hrs. 8. Date of B	
	70	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Anne Arundel Glen Burnie		10d. Inside City Limits 1 □Yes 2 <b>½</b> No
	h with th	al Dire	10e. Street and Number  413 Ridgely Rd.  21061		10g. Citizen of What Country? Unites States
0036	hin 72 hours after death with the Maryland e. an "natural", or Items 23a or 23a-f show Middeal Examinar must be rediffed at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  XX 2 □ No 1943  If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pt Yes, Give Year or Dates:  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pt Yes, Give Year or Dates:  15. Was Decedent Ever in U.S. Armed Forces?  16. Yes, Specify Cuban, Mexican, Pt Yes, Give Year or Dates:  16. Was Decedent Ever in U.S. Armed Forces?  17. Was Decedent of Hispanic Origin' If Yes, Specify Cuban, Mexican, Pt Yes, Give Year or Dates:	? (Specify Yes or N ruerto Rican, etc.)	Specify: White
21215-0036	filed within 72 P Hygiene. other than "nate ent, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Light for the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	working	16b. Kind of Business/Industry  Own Home
	e filed w Il Hygie other ti	Be Col	12 Homemaker  17. Father's Name ( <i>First, Middle, Last</i> )  18. Mother's	Name (First, Middl	e, Maiden Surname)
ylan		To B	Roy C. Elmore Mildr	ed Greis	sman
Maryland	d 2 sho th and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)  Edward W. Bromble, Jr. / Son  615 Old Stage Rd., G		
altimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic each.		20a. Method of Disposition  1 ☐ Purial 2 To Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  J	Date 27, 2009	20c. Location - City or Town, State  Catonsville, Maryland
Balt	permit. Departr Importa any Inju		21. Signat re on A reral Service Licensee  22. Name and Address of Facility  Kirkley-Ruddick  421 Crain HwyS	Funeral B	Home, P.A. Burnie, Maryland 21061
4	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or ea a consequence of):	rdiac or respiratory	errest, Approximate Interval Between Onset and Death
68760,	rificate be executed g physician and as the burial-transit	ledical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):  C.  Due to (or as a consequence of):  d.		
.C. Box	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Directors After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
Hecords, F	equires that en signed t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	tobacco use contribute to the cause of death?  Yes 2 100 3 Probably 4 Unknown
итан жесс	an: The law ratificate has be or, page 2 sho	e Completed	25. Was case referred to medical 26. Place of	— 24a. Wa aut per 1 □ Yes	prior to completion of cause of death? 2 ☐ No
5	ding Physician.  After this cerfuneral direct	ion: To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA  Other: 4 Nursing  27. Manner of Death  Natural 5 Pending  Provided the second of Injury (Month, Day, Year)  And the second of Injury at Work?	ng Home 5 ☐ Re 28d. Describe	sidence 6 Other (Specify)
DIVISION	tal or Attents after death al Director: ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location	(Street and Number or Rural Route Number, own, State)
	he Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and partical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
	Vith Vith Com	2	29b. Signature and filter of certifier  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number  29c. License number	3	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1132 Annapolis Road Odenton, MD 2	21113	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Stinature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Blair Day Month Year **Physician** 0900 M 2009 /Medical Facility Name (If ot institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A HOPKINS BALTIMORE yview If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Days 1 □ M 2 🗙 F 215-40-9175 **Director** MARYLAND 1931 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examinations and Injury or other traumatic event, It is Medical Examinations. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD Hmare 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 21205 States Completed by Funeral 1068 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MARYLAND 1008 HIGNET WAY, LEON BLAIR/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) JULY 1, 2009 BALTIMORE, MARYLAND OAKLAWN CEMETERY 21. Signature of Funer Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks Verrible mis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has autopsy performed? Yes 2 No 1 🗆 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely filled in by the funeral director, page 2 within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
>
> JUL 0 1 2009

29b. Signature and title of certifier

Brown

4940 Eastern 32. Registrar's Signature

veen MA

State Registrar 29c. License number

Baltimore

484

29d. Date signed (Month, Day, Year)

lune, 24

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2009 10:40 A Julianne Bekeny JUN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15410 Partnership Rd <u>Poolesville</u> Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/18/1941 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 K F England 67 Director 128-34-7249 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show if than "natural", or items 23a or 28a-f show the Wedical Evanities must be notified at Montgomery Poolesville MD 1 □Yes 2 TNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20887 United States 15410 Partnership Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕏 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic event, Its once. 12 Childcare Nanny 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Charles Cheshire Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15410 Partnership Rd. Poolesville MD 20887 Gutierrez / POA Thomas Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Chesapeake Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/30/2009 Beltsville MD 4 ☐ Donation 5 ☐ Other (Specify) 933 Gist Ave. Silver Spring MD 22. Name and Address of Facility 21. Signature of Funeral Service License Rapp Funeral & Cremation lau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Motastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has by page 2 s autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No after death Director: / d in by the fi 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in 24 hours the Funeral Directory filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/29/2009 MD060050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Dr. Rockville MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 30 Day 2009° **Physician** Virginia M. Bien June 5:15 AM /Medical 4b. City Town, or Location of Death 4c. County of Death me (If not institution, give street and number) Examiner Wille Ols If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Min. Months Days Hours 1 □ M 2 🗓 F 218-12-8801 1923 Director 85 Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Director Columbia 1 ☐ Yes 2 X No traumatic event, the Medical Examinar must be notified Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a 21046 USA 9277 Cartersville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X)Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify ≥ 3 🕅 Widowed 4 □ Divorced WWII 'natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) B & O Railroad 12 Clerk Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be LaRue A. Wheat George B. Foy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9277 Cartersville Road; Columbia, MD 21046 Donna Mueller Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Garden 7/3/2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Ser M M01050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 2 No Month Day Year 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 200 1∐Yes ≥ 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

after death. filled in by the

or Attending within 24 hours a

To the Funeral D the Hospital

State Registrar

completely

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUL 0 1 2009

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kadswiller

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d, Date signed (Month, Day, Year)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23aPtII, 25 per me 8893,07/01/09dhb

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 11:12 AM CLOPTON WARREN JUNE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Months Days 10 M 2□ F Yrs mare Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Exeminar nast be notified at 1 Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ death with 23a Z Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceded as 2 □ No KYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 2 Married 1 Never Married 1 □Yes 2 No altimore, Maryland 21215-0036 ō Specify Specify: <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) na th 1 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be optor မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Informant's Name/Relationship (Type, Print) Rd. Department of Health ar Important: If item 27 is any injury or other trau once. rne ton 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 57,1 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Here the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or heart failure. List only one cause on each line. Approximate Interval Between set and Death
30 Houes Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician ACUTE /Medical Due to (or as a consequence of): Examiner NHKHOWH ARTERY CORONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran CERTIFIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ INJURY due to myocardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed infarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 215 No 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ After this 24 hours after death.

Funeral Director: After thi etely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) completely and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RESO00 MD JUNE 2009 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed 3001 SOUTH HANDUER STREET, BALTIMERE MARYLAND 21225 ADEKUNLE OBISESAN, MD 32. Registrar's Signature 31. Date filed (Month; Day, Year) State Registrar

DHMH 17 Bev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b-c, perFh 883, 7/14/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 5.47 PM Collier 27 Clarence 0. 06 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samarian Hospital
5. Social Security Number 6. Sex Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Maryland Director 10/29/1930 212-28-1736 78 death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County : If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Evanting must be inviting at Director 1X Yes 2 □ No **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 U.S.A. Funeral 5615 Sagra Road 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1950 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 215-0036 1 ☐ Yes 2 🕱 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory 2 Laborer 10 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Katie Dorsey John Wesley Collier ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615 Sagra Road, Baltimore, Maryland Sherry Turner / Daughter Baltimore, 20b. Place of Disposition (Name of Mt. cemplary crembiory of other place) 20a, Method of Disposition 20c. Location - City or Town, State Pages ' ō 7/7/2009 Lansdowne, MD Owings Mills, Maryland 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: If any Injury or once. Carrison Forest Ceme. 07/08/2009 21. Signature of Funeral Service License 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE CORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SMALL Seque itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed ACUTE and burial-tra Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à RONIC KIDNEY DISFASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed been s Were autopsy findings available prior to completion of cause of death? FIBRELL ATTOM 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records,

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State Registrar

filled in by

Medical

24 hours a

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Kalong

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RAVEN

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↑☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

BLVD. BALTIMOREMD 21239

KABRA SATISH 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

determined

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28 5:20 A M 14174 inc /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALTIMORE MORC Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Months Days 217-86-0394 1 M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "acdical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number il.5.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐Yes 2 🗷 No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SICK cell disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Completed by Physician/Medical Be Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, after death.

Director: After this certificate To the Hospital within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

l	d.								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
Part II. Other significant conditions o	contributing to death but not resulting in the underly	ing cause given in Part I.		se contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No					
25. Was case referred to medical examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [	26. Place of Death	Check only one)	Mother (Specify)					
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	Work?	d. Describe how injur	y occurred					
3 Suicide 6 Could not be determined		actory, office 28	If. Location (Street an City or Town, State	d Number or Rural Route Number, )					
	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.								
29b. Signature and title of certifier		29c. License number	29d. Da	te signed (Month, Day, Year)					

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Reliterstown

6/28/09

21136

MI)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS KAJAPAKS MO 25 MAIN STO SUITE 2

VISILUILDOUNEMD

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Barkon

State of Maryland / Department of Health and Mental Hygiene? [] [] 9 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 07554 M **Physician** MARY ANN CHANEY June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arundel Glen Burnie Anne Baltimore Washington Medical Center Date of Birth (Month, Day, Yea MARCH 29, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Min. Days Hours PA 161.32.5527 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Event in court by notified at once. 1 ☐ Yes 2 XXNo Funeral Director GLEN BURNIE ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 235 POPLAR AVE. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 XXMarried WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 Xio Specify. Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND REVENUE AGENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VICTORIA SUCIU EDWARD HAMAKER မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 235 POPLAR AVE., GLEN BURNIE, MD 21061 MARK CHANEY HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State GLEN BURNIE, MD JUNE 30, 2009 GLEN HAVEN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Lic 22. None and Address of Facility
FINK FUNERAL HOME, P.A. 426 CLEN BURNIE, MD 21061 FINK M01148 23a. Part 1 Enter the rise se, or co-plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart is lure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate use (Fina disease or co dition resulting in de **Physician** CONGESTIVE /Medical Due to (or to a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tune 27, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Center BALTIMORE FRANCIS 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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		,	1 - For State Registrar	State of Ma	aryland /		irtment of tificate of		ind M	-	giene Reg. No.	2000	3 209	994
Ē,	Physici		Doris Novella C							2. Date of De	eath	′ 2009 <sup>ear</sup>	3. Time of D	
	/Medio		4a. Facility Name (If not institution, giv				4b. City, Town,	or Location o	f Death			County of Deat		
T 5 5 4	Funeral Director		5. Social Security Number 6. S 213-30-7005		e (In yrs. last 78	birthday) Yrs.	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Bir Month Da 6-15-	rth	9. Birt Co	hplace (State or untry) RYLAND	Foreign
yland	at		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	cation					13,22	10d. Inside City	Limits
ле Маг	8a-f sl	Director	MD. N/A		BA	LTIM		-					1 XYes	2 □ No
with t	a or 2		10e. Street and Number				10f. Zip Code	_				zen of What Co	untry?	
d 21215-0036  Ifled within 72 hours after death with the Maryland	ur lygjene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at	by Funeral	4849 REISTERSTO  11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced	WN RD.  12. Was Decedent E Armed Forces?  1 ☐ Yes 2√√ N If Yes, Give Year or Dates:		Į į	2121 Vas Decedent of i Yes, specify Cu	Hispanic Oric ban, Mexican	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		USA  14. Race - Ame Black, White  Specify: BL.	e, etc.	
21215-0036 d within 72 hours af	"natura edical E	leted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	10	(Give i	ent's Usual Occu kind of work done OO NOT use retire	during most	of workin	g	16b. Ki	nd of Business/	Industry	
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aryla 2 should	r neath and Mer tem 27 is marke other traumatic	۲	19a. Informant's Name/Relationship (		1	19b. Mailin	g Address (Stree						Zip Code)	
C 7	item 27		GARY T. CARTER	(SON)			OLD COU							
mor Pages	D		20a. Method of Disposition  1 ☑ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif				sition (Name of natory or other pl	1		ate		ecation - City or		
altimore,	Important: I any injury o		21. Signature of Funeral Service ficer				RIAL PAR . Name and Add		-2-2 PHIL				MARYĻANI • P.A.	)
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	/sician fedical	2 (13	23a. Parti. Enter the disease, or com short or heart failure. List only Immedia. Cause (Final diseas.) Ir condition resulting in death)	one cause on each lin	INSON	3'5	7	ing, such as	cardiac o	respiratory a	arrest,		Approximate Interval Betw Onset and De	een eath
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58760, icate be exe	physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	a consequenc	ce of):								
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<b>T</b> #	s been signed by should be deta	by	Part II. Other significant conditions of	contributing to death bu	,		derlying cause g	ven in Part I.					the cause of de	
VITAL RECORDS, P.O sician: The law requires that the		Completed								24a. Was auto perfo		prior to death?	topsy findings at completion of cal	vailable use of
/ITal	certificate ha	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only		12103	2010	
Phys O	this aldi	은	1 Yes 2 No	Hospital: 1 ☐ Inpatier  28a. Date of Injur		Outpatient	3 LI DOM					6 □Other (Spe	cify)	
on and a	r: After	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Inji We M 1 [	ork? ]Yes 2∐1		8d. Describe	now injur	y occurrea		
To the Hospital or Attending within 24 hours after death	To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju building, etc	ry - At home, c. (Specify)	, farm, stre	eet, factory, office		2	8f. Location ( City or To	Street an wn, State	d Number or Ru	ıral Route Numb	er,
e Hospi	e Funer letely fill	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one)	y <b>siclan:</b> To the best on niner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the restigation, in my	ime, date and opinion, dea	d place, a th occurre	and due to the	cause(s) , date and	and manner as d place, and due	stated. to the cause(s)	
To the wifeign	To th comp	Me	29b. Signature and title of certifier				29c. Licer	se number			29d. Dat	te signed (Mont	h, Day, Year)	
			tah, son	<del></del>				258	08		6	12910	9	
			30. Name and address of person who ENVOY NUR	completed cause of de			Print) SVILLE 7	SUDBR	ROOK	LANE P	IKES	VILLE	21208 MARYLANI	)
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 1 20	32. Registra	r's Signature		Klad							

DHMH 17 Rev 1/2001

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AMEND ITEM# 195, Perfff, 6894, 8 6 6 9 9, WS

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 23a PtII, 25 per me, 8893, 07/01/09dhb

Reg. No. 2 1 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** рм Vivian 3:10 E. Drake 6 19 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 208 S . Social Security Number Spring Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 8-5-1939 Age (In yrs. last birthday) **Funeral** Days Hours 219-26-7806 1 □ M 2 🗓 F 69 Director MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show Department of Health and Mental Hygiene. "Internation items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite. "Included Experiment as the retified at any Injury or other traumatic event, Ite. "Included Experiment and Injury or other traumatic event, Ite." Included Experiment and Injury or other traumatic event, Ite. "Included Experiment and Injury or Open." XXYes 2□No Director MD Baltimore N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 208 S. Spring Street 21231 S A Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dewitt Henderson Catherine Maddox ပ 1961 illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Renee D. Henderson-Daught 101 New Hope Court Baltimore, MD 21202 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 6-30-2009 Owings Mills, MD 21202 22. Name and Address of Facility 21. Signature of Fun ral Service Licensee March East F/H Brownille 1101 E. North Avenue Balto, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MEDICAL EXAMINER Hospital or Attending PhysIclan; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): CERTIFICA Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) icate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 A due to Metastatic Lung Cancer 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 25. Was case referred to medical examiner?

1 X Yes funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) 57 PAUL PC BANTMONO M21202 22 32. Registrar's Signature State Registrar

		-	For Amend Items 2: - State Registrar	Ja 1 CI , 25	рет-1	Certi	ficate of	Death	R	Reg. No. 2	19	20996
	Dhuaisia		1. Decedent's Name (First, Middle, Last)	Danka	m	D			2. Date of Dea Month	Day Y	'ear	3. Time of Death
	Physicia /Medic			Donta	т.	Dunl			June		09	05:23AM
	Examin	er	4a. Facility Name (If not institution, give s Union Memorial	street and number) Hospita	a l	4	b. City, Town, o Balto	r Location of Death	U	4c. County of N/A	Death	
-	Euroval		5. Social Security Number 6. Sex		(In yrs. lasi		f Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h I S	. Birthpla	ce (State or Foreign
	Funeral Director		219-94-8447 M	<b>M</b> M 2□ F	29	Yrs.	Months Days	Hours Min.	(Month, Day 1-8-1		Country	MD
	p ,		Usual Residence of Decedent  10a State 10b, County		Inc. City 7	Town or Locat	ion				100	. Inside City Limits
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	ter death with the Marylan items 23a or 28a-f show	Funeral Director	2064 Kennedy Av	venue				21218		US	A	
	death	ner		12. Was Decedent Ever Armed Forces?	er in U.S.	13. Wa	s Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race	Americar White, etc	
36	hours after death with the Maryland tural", or items 23a or 28a-f show at Erad and must be mailfind at	by Fu	1 XNever Married 2 Married	1 □Yes 2 No If Yes, Give			Yes <b>≱(∑K</b> √lo	Specify:	,		Bla	
21215-0036	be filed within 72 hours aft ntal Hygiene. ed other than "natural", or event, I'n Medical Eval.	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:		 16a. Deceder	nt's Usual Occup	pation		16b. Kind of Busi	ness/Indu	stry
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Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	e 1/6	2	22. 1	lame and Addre	ess of Facility Ma	arch Ea	ast F/H		
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			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the cause on each line								Approximate nterval Between Doset and Doath
Lange	Physician		Immediate Cause (Final disease or condition resulting in death)	_ +116	_			ntravascı		guration	4	Juan 5
-	/Medical Examiner		resolung in dealin)	1		- 4 /	1014	Infiltrat	tes		5	weeks
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	De to (or as a	consequer	nc of):	ry w.C.		///	2		years
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oʻ	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or as a	conseque	nce of):	11	CERTIFICATION	PPROVED BY N	MEDICAL EXAMINER	1	
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σ.	ires that signed I I be deta	by P	Part II. Other significant conditions con	ntributing to death but	not resulti	ing in the und	erlying cause gi	ven in Part I.		obacco use contri		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>009</u> **Physician** WILLIAM LOUIS DeSANTIS, SR. 3:10 A M JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MANOR CARE ROSSVILLE ROSEDALE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-5-1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. **№** M 2 🗆 F Days Hours MARYLAND 220-09-3274 92 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be nothing at 1 ☐ Yes 2 X No Director BALTIMORE ROSEDALE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2342 HAMILTOWNE CIRCLE 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify. \$ WHITE 3 X Widowed 4 ☐ Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) BALTIMORE CITY RECREATION AND PARKS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK DeSANTIS, SR. MARY VICTORIA (GALLO) ပ 19a. Informant's Name/Relationship (Type. Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM L. DeSANTIS, JR. 2342 HAMILTOWNE CIRCLE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH | 7-3-2009 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ROSEDALE, 21237 <del>12</del>11 CHESACO AVE MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Obstructive Pulmonary Discusse Immediate Cause (Final Due to (or as a sinsequence of): disease or condition resulting in death) Chronic Year, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ermonia 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Medical

**Physician** /Medical **Examiner** sician and burial-transit P.O. Box 68760 Division of Vital Records. To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

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with the Maryland

Maryland 21215-0036

Baltimore,

Health i

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Rd, Elliatt City, MD

State Registrar

DHMH 17 Rev 1/2001

2009

Andres

32. Registrar's Signature A. parked

362

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salazar

			1 - For State Registrar		State of Ma	iryiand /		rtificate of		a Ment		eg. No.	200	39	20	998
	Physici	an	1. Decedent's Name (First, Mic							M	ate of Deat onth	Day		/ear	3. Time o	
44	/Media	cal	John Martin					T			ne	26		009	732	a <sup>M</sup>
	Examir	ier	4a. Facility Name (If not instituted Holy Cross He		,			Silver	or Location of De	eatn			County of			
- 44	Funeral		5. Social Security Number	6. S		(In yrs. last b	irthday)	If Under 1 Year	If Under 24 H	lrs. 8. Da	ate of Birth			9. Birthp	lace (State	or Foreign
	Director		212-40-1299	1	<b>⊠</b> M 2□ F	67	Yrs.	Months Days	Hours Mi		n • 24 ,		2 1	Couin Mich	<i>try)</i> igan	
TO C	2		Usual Residence of Decedent 10a. State 10b. Cour	241/		10c. City, Tov	un or Lo	nonting						110	Od. Inside C	ity   imite
27	sho	5														2 X No
he M	28a-f	Director	MD Monto	gome	ery	Burto	nsvi	10f. Zip Code			1	Oa Citi	zen of Wh	at Coun		
diw	Saor	اقا	3905 Dunes W	av				20866			'		SA	iai ooan	y :	
teath	ms 2.	Funeral	11. Marital Status		12. Was Decedent E	ver in U.S.	13.	Was Decedent of I		(Specify Y	es or No-		14. Race			
<b>036</b>	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "model Eventral" in the notified at	by	1 ☐ Never Married 2 🔀 M 3 ☐ Widowed 4 ☐ Divorc		Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo		If Yes, specify Cub 1 □ Yes 2 No		ierto Rican	, etc.)		Black,	White, e whit		
5-0 2 Pe	natur	eted	15. Deced (Specify only hig	lent's Ed	lucation	16	a. Dece	dent's Usual Occu	pation	vorkina		16b. Ki	nd of Busi	10	lustry	
<b>7</b>	ne.	Completed	Elementary/Secondary (0-12	Ť	College (1-4or 5-			kind of work done DO NOT use retire		vorking		-	<i>8 * <sup>5</sup></i>			
22	filed w Hygie ther t	ဒီ	43 5 11 1 1 1 1 7 7 7 1 1 1 1 1	//- / A	4	S	ales	Manager		1 (Fina	4 8 61 41 41 4 8		mpute			
Maryland 21215-0036	Mental F arked ot atic ever	To Be	Daniel Daly	17. Father's Name (First, Middle, Last) Daniel Daly				18. Mother's Name (First, Middle, I Gladys Otto				Maiden Surname)				
	and 2 should be and 2 should be leath and Mental m 27 is marked oher traumatic even		19a. Informant's Name/Relation Barbara M. Ca			1		ng Address (Street Dunes W				_			Code)	
Baltimore, permit. Pages 1 ar	Department of Hilmportant: If iter any injury or oth once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cremator West Arund													
<b>a</b>	porta porta y inju		21. Signature of Funeral Servi			.!	22	2. Name and Addre			dson	Fun	eral	Hom	e, P.	Α.
<b>n</b> 8	29 = 9	V iii	Je Ken Stila			101053	4 3	313 Talbo	tt Ave.	, Lau	rel,	MD			1111	
	nysician	á. V	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a End Stage Dementia													
	Medical xaminer		resulting in death)		Due to (or as a	consequence	of):									
		Jer	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury	J	b. Due to (or as a	a consequence	of):									
cuted	nd ransil	Examiner	that initiated events	1	C									1.		
68760, rificate be executed	attending physician and for use as the burial-transit		resulting in death) Last		Due to (or as a	consequence	of):									
<b>68760,</b> ificate be ey	physic the b	edical			d									+		
			IF FEMALE:		23c. If yes, outcome of	of pregnancy						Τ,	Old Data	of dollars		
O. BOX he death cer	he death cei the attendir thed for use	hysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1  Live birth 2 Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5 Other (specify)				су				23d. Date of delivery  Month Day Year			
ords, P.O. requires that the	s been signed by the should be detached	σ.								ıse contrib	ontribute to the cause of death?					
ecords, aw requires t	n sign id be	d by				_				_	1 🔲 Ye	es 2[	□ No 3	B∐ Prob	ably 4	Unknown
aw re	s bec 2 sho	Completed								2	4a. Was a		24b. W	ere auto	psy findings	available
Y e	ate h	mo.								_	autops perforr	sy med? 2. <b>⊠</b> No	de	ior to coi eath? ⊒Yes	mpletion of o	cause of
	ertifica ctor, p	Be C	25. Was case referred to medi examiner?	cal					26. Place of D				1		2 23110	
OT VITA Physician:	his ce I direc	일	1 Yes 2 ⊠ No		Hospital: 1XXnpatie	nt 2 ER/C	utpatier	nt 3 DOA Oth	ner: 4 🗆 Nursing	g Home	5 ☐ Reside	ence (	6 □ Other	(Specif	y)	
C 5	ign life		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Vork? Injury 4 Work? 1 Yes 2 No							28d. [	28d. Describe how injury occurred					
DIVIS al or Atte	s after des	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be ermined	28e. Place of Inju building, etc	ry - At home, f . <i>(Specify)</i>	arm, str	eet, factory, office		28f. L	ocation (St	treet an n, State	d Numbei )	r or Rura	l Route Nur	mber,
e Hospit	within 24 hours after death.  To the Funeral Director: All completely filled in by the fu	Medical C	29a. Certifier  (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
) to	withis To th. comp.	Me	29b. Signature and title of certifier 29c. License number D63579								29d. Date signed (Month, Day, Year) June 26, 2009					
			30. Name and address of person who completed cause ordeath tem 23a) (Type, Print)  Maria J. Tayag, MD, 1500 Forest Glen Rd., Silver Spring, MD 20910													
	Sta	te	31. Date filed (Month, Day, (e.	ır)	32 Penietro	r'e Signaturo				5 7			-			
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	Registrar  1. Decedent's Name (First, Middle, Last)	Octimodic of Dealit	Reg. No.  2. Date of Death  3. Time of Death
Physician /Medical	Henrietta Bair Dixon		June 27 2009 4:05 A
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	
	Reeder's Memorial Home	Boonsboro  s last hirthday) If Under 1 Year   If Under 24 F	Washington  Its. 8. Date of Birth 9. Birthplace (State or Foreign
Funeral Director	4 D M 057 E		Irs. 8. Date of Birth (Month, Day, Year) Aug. 19, 1915   Maryland
	Usual Residence of Decedent		10d. Inside City Limits
arylaı shov		City, Town or Location	1 X Yes 2 □ No
the M	Maryland Frederick  10e. Street and Number	Frederick  10f. Zip Code	10g. Citizen of What Country?
firer death with the Mar frems 23a or 28a-f s instraust by notified Funeral Director	501 Prospect Blvd., Apt. 3B	21701	U.S.A.
death	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	1 □Yes 2 🗷 No Specify:	Specify: White
etta 215-003 hin 72 hours a e. an "natural", o Modelle ea	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215 215 215 2 215 2 215	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of v life. DO NOT use retired)	vorking
nrietta d 21215-0 flied within 72 hou they than "nature ant, the medical E	11	nurse	hospital
Maryland 21215-( Maryland 21215-( d 2 should be filed within 72 h thand Mentall Hygiene. To see ther than "naturating event, the Medical Complete.  To Be Complete.	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maiden Surname)
aryla should I and Men warke umatic	Reuben Bair  19a. Informant's Name/Relationship (Type. Print)		Jillian Smith  Rural Route Number, City or Town, State, Zip Code)
Ma Ma Idan Ithan traur	Charles A. Dixon/ husband	501 Prospect Blvd.,	
Dixon, re, Mar s 1 and 2 sh of Health and item 27 is m other traum		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Pages nent of ant: If its	1 1 Viburial 2 I (Cremation 3 I Hemoval from State		80/2009 Woodsboro, MD
逆 교환원등	21. Signature of Funeral Service Licenses	22. Name and Address of Facility	Hartzler Funeral Home
Ball Ball beau Important in portant	Of But State of the State of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	404 S. Main St.	Woodsboro, MD 21798  Tiac or respiratory arrest. Approximate
110000	23a. Part 1. Enter the disease, or complications that called the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final	aun. Do not enter the mode of dying, such as care	Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)  Due to (or as a cons	Lyance of):	uliq
Examiner		equence of).	
in er d	Sequentially list conditions, that it, leading to finite class cause. Enter Underlying	equence of):	
executed in and individual transit	Cause (Disease or injury that initiated events resulting in death) Last		
68760, filcate be executed physician and is the burial-transit	resulting in death) Last Due to (or as a cons	equerice or).	
	d		
Box 66 death certific to attending p for use as	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ F		23d. Date of delivery
Division of Vital Records, P.O. Box and or Attending Physician: The law requires that the death cert after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a settification: To Be Completed by Physician/IM.	1 Yes 2 10 4 Pregnant at time of		Month Day Year
P.C nat the cd by t letach	9 Unknown  Part II. Other significant conditions contributing to death but not r	eculting in the underlying teause given in Part I	23e. Did tobacco use contribute to the cause of death?
ds, P.O. I	Hy Denton Dim ,	Dura ha O10	1 ☐ Yes 2/1 ☐ Yo 3 ☐ Probably 4 ☐ Unknown
cord w requir s been s should leted	1//2:00:	79/100801	24a. Was an 24b. Were autopsy findings available
of Vital Record hysician: The law requires certificate has been soldirector, page 2 should To Be Completed			— autopsy prior to completion of cause of death?
ital an: T an: T tor, pc	25. Was case referred to medical	26. Place of I	1 □ Yes 2 □ No   1 □ Yes 2 □ No Death (Check only one)
of Vi hysicii this cer al direct	examiner? 1 Yes No Hospital: 1 Inpatient 2	- A - A	g Home 5 ☐ Residence 6 ☐ Other (Specify)
ing Pl	27. Manner of Death 28a. Date of Injury (Month, Day, Year,		28d. Describe how injury occurred
ISIO ttend death. ttor: // the fi	2 Accident investigation	M 1 Yes 2 No	204   coption (Charatand Number or Dum) Doute Number
Division c tal or Attending P rs after death. all Director: After I led in by the funera Certification:	4 Homicide determined building, etc. (Spe	home, farm, street, factory, office cify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ospita hours uneral ly fillec			lace, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death or Attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
P is P o	7 / A	M > D0063233	0/107129
8	30. Name and address of person who completed cause of death (I		06/27/01
0	Dr. Shahid Mahmood 580 Norther	rn Avenue, Hagerstown,	MD 21742 301-733-4496
State Registrar	31. Date filed (Month, Day, Year) 32. Jegistrar's Sig	A. Sarl	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:35 AM JUNE 27 2009 /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Memorial Ka Homore If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Months 1 1 M 2 □ F -30-46 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evanting must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director Marylar 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 NO 1 ☐ Yes 2 ☑ No Specify δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Yellow Cat Elementary/Secondary (0-12) College (1-4or 5+) 26 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christabe Smackium-sister 20b. Place of Disposition (Name of cemptery, crematory or other) Date 20a. Method of Disposition 1 Burial 2 Cremation Mar 3 ☐ Removal from State emator 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ~5 days **Physician** wrosepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner prostate cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans HIV Due to (or as a consequence of) the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I I Inknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Be Completed Certification: To

that the death certificate be execute Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

		1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 2 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No		
25. Was case referred to medical	26. Place of Deat	h (Check only one)		
examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)		
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Number or Rural Route Number City or Town, State)		

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

2009

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL, BALTIMORE, MD UNION

. Registrar's Signature